

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**HOME AND COMMUNITY-  
BASED SERVICES IN ASSISTED  
LIVING FACILITIES**



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## **EXECUTIVE SUMMARY: HOME AND COMMUNITY-BASED SERVICES IN ASSISTED LIVING FACILITIES, OEI-09-08-00360**

### **WHY WE DID THIS STUDY**

Under the 1915(c) waiver, the Centers for Medicare & Medicaid Services (CMS) may waive certain requirements to allow State Medicaid programs to cover home and community-based services (HCBS) for beneficiaries residing in assisted living facilities (ALF). However, little information exists about the HCBS furnished to beneficiaries in ALFs, the costs of those HCBS, or the extent to which those HCBS are furnished in compliance with Federal and State requirements.

### **HOW WE DID THIS STUDY**

To identify the costs and types of HCBS covered under 1915(c) waivers for Medicaid beneficiaries residing in ALFs, we surveyed and collected claims data from 35 State Medicaid programs. From these 35 States, we selected the 7 States with the highest numbers of beneficiaries receiving these services in ALFs: Georgia, Illinois, Minnesota, New Jersey, Oregon, Texas, and Washington. Using claims data from these 7 States, we selected a random sample of 150 beneficiaries. To determine the extent to which Medicaid programs complied with Federal and State requirements for HCBS furnished under the waiver, we reviewed State survey agency inspection reports for ALFs in which beneficiaries from our sample resided. We also reviewed plans of care associated with the sampled beneficiaries. The period of our review was 2009.

### **WHAT WE FOUND**

In 2009, 35 Medicaid programs reported that, under 1915(c) waivers, they covered various HCBS for beneficiaries in ALFs at an annual cost of \$1.7 billion. Each State had federally mandated provider standards; however, ALFs in the seven selected States did not always comply with them, and federally required plans of care did not always meet Federal requirements. In the seven States, 77 percent of beneficiaries received HCBS under the waiver in ALFs cited for a deficiency with regard to (i.e., noncompliance with) at least one State licensure or certification requirement. Nine percent of beneficiaries' records did not include plans of care required by the States. Further, 42 percent of the federally required plans of care did not include the frequency of HCBS furnished, as required. Five of the seven States also required that plans of care specify the beneficiaries' goals and the interventions to meet them. In these 5 States, 69 of 105 plans of care for beneficiaries receiving these services in ALFs did not meet that requirement. Two of the seven States also required that plans of care be signed by beneficiaries or their representatives. In these 2 States, 12 of 25 plans of care for beneficiaries receiving HCBS in ALFs did not meet that requirement.

### **WHAT WE RECOMMEND**

We recommend that CMS issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver. CMS concurred with our recommendation.

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## OBJECTIVES

1. To identify the costs and types of home and community-based services (HCBS) covered under the 1915(c) waiver for Medicaid beneficiaries residing in assisted living facilities (ALF).
2. To determine the extent to which State Medicaid programs complied with selected Federal and State requirements for HCBS furnished under the 1915(c) waiver.

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## BACKGROUND

In recent years, State Medicaid programs have attempted to expand long-term care options for beneficiaries while reducing spending for institutional long-term care, which is provided primarily in nursing facilities.<sup>1</sup> ALFs can provide a housing alternative to institutional care for individuals who prefer to live independently but need assistance to maintain their independence.

State Medicaid programs cover HCBS for beneficiaries residing in ALFs under several authorities. Although ALFs are not defined in Federal health care law and regulations, a congressional workgroup<sup>2</sup> defined them as “State regulated and monitored residential long-term care options that provide or coordinate oversight and services to meet the residents’ individualized scheduled needs, based on the residents’ assessments and service plan and their unscheduled needs as they arise.”<sup>3</sup> The term “ALF” may include facilities referred to as “adult foster homes” or “residential care facilities.” Residents of ALFs may include Medicaid beneficiaries as well as nonbeneficiaries (i.e., private payers).

HCBS may include case management services, homemaker services, personal care services, home health aide services, and other services necessary to avoid institutionalization.<sup>4</sup> Homemaker services consist of housekeeping, laundry, and meal preparation, whereas personal care

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<sup>1</sup> U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Understanding Home and Community Services: A Primer*, October 2000. Accessed at <http://aspe.hhs.gov/daltcp/reports/primer.htm> on January 16, 2009.

<sup>2</sup> In 2001, at the request of the U.S. Senate Special Committee on Aging, approximately 50 organizations representing providers, consumers, long-term care and health care professionals, and regulators formed the Assisted Living Workgroup to develop recommendations to ensure quality in assisted living.

<sup>3</sup> Assisted Living Workgroup, *Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging*, 2003, p. 12. Accessed at <http://www.theceal.org/assets/PDF/ALWReport-Definition-and-Core-Principles.pdf> on May 7, 2010.

<sup>4</sup> 42 CFR § 440.180(b).

services consist of assistance with activities of daily living and supervision. Activities of daily living typically include, but are not limited to, bathing, dressing, using the toilet, and walking. Home health aide services consist of some nursing assistance, such as medication management and checking pulses and blood sugar levels. These services are designed to help older individuals and individuals with disabilities to continue living at home or in other noninstitutional residential community settings, such as ALFs.<sup>5</sup> HCBS may be furnished by individual providers and/or agency providers, such as ALFs.<sup>6</sup>

State Medicaid programs cover HCBS for beneficiaries residing in ALFs under their State Medicaid plans, 1915(c) waivers,<sup>7</sup> or section 1115 research and demonstration waivers.<sup>8</sup> Of the three methods, the 1915(c) waiver is the most common. In 2009 (the period of our review), 37 Medicaid programs covered HCBS in ALFs under the 1915(c) waiver, 13 programs used their Medicaid State plans, and 4 used the section 1115 research and demonstration waiver.<sup>9, 10</sup>

Between 2002 and 2009, the number of beneficiaries receiving HCBS in ALFs under the 1915(c) waiver and section 1115 research and

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<sup>5</sup> HCBS may also be furnished in noninstitutional settings, such as adult day health centers and day treatment centers.

<sup>6</sup> Centers for Medicare & Medicaid Services (CMS), *Application for a § 1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guidance and Review Criteria (Application)*, January 2008, p. 136.

<sup>7</sup> The 1915(c) waivers allow State Medicaid programs the flexibility to cover a wide range of HCBS through the waiver of certain State plan requirements. Under section 1915(c), CMS may waive the following requirements: (1) Statewide—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 (SSA) § 1915(c)(3); CMS, *Application*, January 2008, pp. 5-6.

<sup>8</sup> Waivers under section 1115 of SSA allow Medicaid programs the flexibility to design and improve their Medicaid and Children's Health Insurance Programs. CMS, *1115 Waiver Basics*. Accessed at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstration.html> on June 15, 2012.

<sup>9</sup> Robert L. Mollica, *State Medicaid Reimbursement Policies and Practices in Assisted Living* (prepared for the National Center for Assisted Living and the American Health Care Association), September 2009, p. 7. Accessed at <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf> on October 19, 2011.

<sup>10</sup> The total number of State Medicaid programs exceeds 50 because 6 of the programs cover HCBS in ALFs both under their State plans and under waivers.

demonstration waiver increased 122 percent.<sup>11</sup> Although the population of Medicaid beneficiaries in ALFs has seen significant growth in recent years, little information exists about HCBS furnished to beneficiaries residing in ALFs and the costs of those HCBS. In addition, little is known about the extent to which HCBS are furnished in compliance with Federal and State requirements.

HCBS furnished under the 1915(c) waiver. The 1915(c) waiver allows State Medicaid programs flexibility through CMS's waiver of certain State plan requirements. Specifically, it allows these programs to cover a wide range of HCBS (other than room and board) for individuals who meet the Medicaid eligibility requirements for institutional care.<sup>12</sup> Any Medicaid program that chooses to implement a waiver program must submit a waiver application to CMS for review and approval.<sup>13</sup>

### **Federal and State Requirements**

Pursuant to Federal requirements, to be granted a 1915(c) waiver, a State Medicaid program must include certain provisions in its waiver application. These include, but are not limited to, assurances that necessary safeguards have been taken to protect the health and welfare of beneficiaries and that providers will furnish HCBS under written plans of care.<sup>14, 15</sup> Among other things, these provisions require the following:

- The safeguards must specify adequate standards for all types of providers<sup>16</sup> that furnish HCBS under the waiver.<sup>17, 18</sup> In addition, Medicaid programs must use existing State ALF licensure or

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<sup>11</sup> Because these data were available only in the aggregate, the increase in the percentage of beneficiaries who received HCBS in ALFs under the 1915(c) waiver also includes beneficiaries who received HCBS under the 1115 research and demonstration waiver. Robert L. Mollica, *State Medicaid Reimbursement Policies and Practices in Assisted Living* (prepared for the National Center for Assisted Living and the American Health Care Association), September 2009, p. 7. Accessed at <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf> on October 22, 2010.

<sup>12</sup> SSA § 1915(c)(1).

<sup>13</sup> Initial waivers are approved for a 3-year period and may be extended for additional 5-year periods. 42 CFR §§ 441.304(a) and (b).

<sup>14</sup> 42 CFR §§ 441.301(a)(1) and 441.301(b)(1)(i).

<sup>15</sup> In their waiver applications, Medicaid programs designate an agency and/or type of provider (e.g., registered nurse) that will complete the plan of care.

<sup>16</sup> "Provider" refers to any individual or entity that furnishes Medicaid services under an agreement with a Medicaid program. 42 CFR § 400.203.

<sup>17</sup> 42 CFR § 441.302(a)(1).

<sup>18</sup> CMS, *Application*, January 2008, p. 137.

certification requirements as the provider standards.<sup>19, 20</sup>

- The written plan of care<sup>21</sup> is to be based on an assessment<sup>22</sup> of the individual to determine the services needed to prevent institutionalization.<sup>23</sup> Each plan of care must identify, at a minimum:
  - the medical and other services to be provided,
  - the frequency of these services, and
  - the type of provider expected to furnish them.<sup>24, 25</sup>

*State Medicaid programs' additional waiver requirements.* In their applications for 1915(c) waivers, State Medicaid programs may specify additional requirements for what a plan of care must include. Such additional requirements include, but are not limited to:

- the beneficiaries' specific goals and interventions to meet them and
- the signatures of beneficiaries or their representatives.

Medicaid programs must implement their waivers as specified in their approved applications, including any additional requirements related to plans of care.<sup>26</sup>

*State licensure or certification requirements.* Generally, a State's licensure or certification requirements address the health and welfare of facility residents, physical plant requirements, staff qualifications and training, and State-required plans of care. States' licensure or certification

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<sup>19</sup> CMS, *Application*, January 2008, p. 136.

<sup>20</sup> Employees of an ALF furnishing HCBS on behalf of the ALF may also be required to possess qualifications mandated under the State's ALF licensure or certification requirements or specified in the Medicaid program's approved 1915(c) waiver.

<sup>21</sup> 42 CFR § 441.301(b)(1)(i).

<sup>22</sup> "The term 'assessment' means an examination of an individual who has been determined (through an evaluation) to meet the level of care requirements for participation in a waiver, to determine what waiver services are needed to prevent institutionalization or whether waiver services constitute an acceptable alternative to institutional care." CMS, *State Medicaid Manual*, Pub. 45, ch. 4 ("Services"), § 4442.6, p. 4-455.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> CMS, *Application*, January 2008, p. 55.

<sup>26</sup> Ibid., p. 6.

requirements mandate that facilities develop and maintain plans of care as part of residents' records.<sup>27</sup>

States use a variety of agencies (survey agencies) to monitor compliance with State licensure or certification requirements. Survey agencies are State entities authorized to set and enforce standards for Medicaid providers.<sup>28</sup> These agencies periodically inspect facilities to determine whether they comply with State licensure or certification requirements. When survey agencies determine that facilities such as ALFs do not comply with these requirements, they typically document such noncompliance as a “deficiency,” in the form of a citation.

*State Medicaid program assessment of compliance with 1915(c) waiver requirements.* In their waiver applications, State Medicaid programs must describe how they will monitor the furnishing of HCBS under the approved waivers to ensure that each assurance is met.

State Medicaid programs must describe the types of data they will collect, which may include—among other things—record reviews, interviews with beneficiaries and providers, and the results of licensure or certification reviews. Medicaid programs must also describe their methods for correcting any problems they find. The processes that Medicaid programs use to monitor operations under the waiver are referred to as “discovery,” and the methods used to address areas of noncompliance are referred to as “remediation.”<sup>29</sup>

### **CMS Oversight of HCBS Under the Waiver**

CMS is responsible for determining whether State Medicaid programs comply with the Federal requirements for covering HCBS under the 1915(c) waiver. CMS reviews the programs' applications for waivers to determine whether the applications: (1) are complete,<sup>30</sup> (2) include the required provisions, and (3) describe how State Medicaid programs will monitor HCBS furnished under the waiver.<sup>31</sup> If CMS determines that the application includes the required provisions and describes adequate monitoring systems, it may approve the waiver for a 3-year period.<sup>32</sup> For those waivers that allow services to be furnished to individuals covered

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<sup>27</sup> CMS, *State Operations Manual*, January 7, 2011, Appendix PP, F279 §§ 483.20(d) and 483.20(k). These plans of care are required in addition to those developed by State Medicaid programs pursuant to the Federal requirements.

<sup>28</sup> SSA §§ 1902(a)(9) and 1902(a)(33).

<sup>29</sup> CMS, *Application*, January 2008, pp. 10-11.

<sup>30</sup> *Ibid.*, p. 6.

<sup>31</sup> CMS, *Interim Procedural Guidance for Conducting Community-Based Services (HCBS) Waiver Programs*, 2007.

<sup>32</sup> 42 CFR §§ 441.304(a). See also 42 CFR §§ 430.25(h)(2)(i).



under both Medicaid and Medicare—dual eligibles—CMS may approve them for a 5-year period.<sup>33</sup> Existing waivers may be renewed for additional 5-year periods.<sup>34</sup>

*CMS quality reviews of HCBS under 1915(c) waivers.* CMS conducts quality reviews of HCBS covered by State Medicaid programs under 1915(c) waivers to determine whether the programs are complying with the Federal requirements. For waivers becoming eligible for renewal on or after January 1, 2010, CMS begins to conduct quality reviews of HCBS covered under the waivers 24 months prior to the waivers' expiration.<sup>35</sup> As part of these quality reviews, CMS requests that programs provide documentation that the Federal requirements are being met. The documentation covers programs' monitoring activities, including any actions taken to correct noncompliance. CMS reports its findings from these reviews to the Medicaid programs at least 1 year prior to the waivers' expiration. This gives the Medicaid programs time to correct any noncompliance prior to the waivers' expiration.<sup>36</sup>

### **Other Studies**

The Office of Inspector General (OIG) conducted a separate evaluation on 1915(c) HCBS waiver programs that examined CMS's oversight of State efforts to ensure the quality of care furnished under such programs.<sup>37</sup>

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## **METHODOLOGY**

### **Scope**

This evaluation focused on 35 Medicaid programs that covered HCBS under the waiver for aged and/or disabled Medicaid beneficiaries residing in ALFs.<sup>38</sup>

The period of our review was 2009.<sup>39</sup> We identified the extent to which the 35 programs covered HCBS under the 1915(c) waiver and the cost of

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<sup>33</sup> The Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), P.L. 111-148, section 2601 (amending section 1915(h) of the SSA). See also 77 Fed. Reg. 26362 (May 3, 2012) (proposed rule to revise 42 CFR § 430.25 to implement section 2601 of the Affordable Care Act).

<sup>34</sup> 42 CFR § 441.304(b). See also 42 CFR § 430.25(h)(2)(i).

<sup>35</sup> CMS, *Interim Procedural Guidance for Conducting Community-Based Services (HCBS) Waiver Programs*, 2007, p. 3.

<sup>36</sup> *Ibid.*, p. 4.

<sup>37</sup> OIG, *Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs*, OEI-02-08-00170, June 2012.

<sup>38</sup> Although 37 States covered HCBS under the 1915(c) waiver, 2 States did not cover HCBS during our period of review because their waiver programs were in the early implementation stage.

<sup>39</sup> Although the period of our review was 2009, we did not complete our site visits to ALFs until March 2010.

those HCBS to Medicaid. We assessed Medicaid programs' compliance with selected Federal requirements relating to beneficiary health and welfare and plans of care. For programs that specified additional requirements in their approved 1915(c) waivers, we also assessed compliance with those requirements.

However, we did not conduct a medical review to determine whether HCBS were furnished in accordance with a plan of care, nor did we assess the appropriateness of the HCBS.

*Compliance with selected Federal and State requirements.* For HCBS covered under the 1915(c) waiver, we assessed the State Medicaid programs' compliance with (1) the provider standards and (2) the plan of care requirements. For the latter, we focused on whether the plans of care identified:

- the medical and other services to be provided in ALFs,
- the expected frequency of these services, and
- the type of provider expected to furnish them.

For State Medicaid programs with approved 1915(c) waivers that specified additional requirements relating to plans of care, we also focused on whether they included:

- the beneficiaries' specific goals and interventions to meet them and
- the signatures of beneficiaries or their representatives.

We also determined whether ALFs maintained (had on the premises) the plans of care as mandated by State licensure or certification requirements.

### **Data Collection and Sample Selection**

*Survey of State Medicaid programs.* We surveyed State Medicaid programs in 49 States and the District of Columbia<sup>40</sup> to collect information about HCBS furnished to beneficiaries who resided in ALFs. Our survey determined that 35 programs covered HCBS for aged and/or disabled beneficiaries in ALFs under 40 1915(c) waivers.<sup>41</sup> The information collected from the 35 States includes, but is not limited to, what types of HCBS are furnished, how many beneficiaries receive HCBS as ALF

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<sup>40</sup> For the purpose of this report, we include the District of Columbia as one of the States. Arizona was excluded from the survey because Arizona operates its Medicaid program under a section 1115 research and demonstration waiver.

<sup>41</sup> Thirty-seven Medicaid programs covered HCBS for beneficiaries residing in ALFs; however, claims data did not exist for two of those States during our period of review because their waiver programs were in the early implementation stage. Some States operate under more than one 1915(c) waiver; as a result, the number of waivers exceeds the number of States with waivers.

residents, what the annual cost of furnishing those HCBS is, and whether documentation of provider standards existed.

Medicaid claims data for HCBS furnished in ALFs. We collected Medicaid claims data from 35 States that covered HCBS for beneficiaries residing in ALFs. Using these data, we selected a purposive sample of seven States with the highest numbers of beneficiaries receiving HCBS in ALFs: Georgia, Illinois, Minnesota, New Jersey, Oregon, Texas, and Washington. We then created a database of 2009 claims data from these 7 States,<sup>42</sup> containing 191,673 claims for 33,652 beneficiaries. Nationally, the seven States represented 62 percent of all beneficiaries receiving HCBS under the 1915(c) waiver in ALFs and accounted for 64 percent of all 1915(c) waiver spending for HCBS furnished in ALFs over a 3-month period.

State licensure or certification inspection reports for ALFs. To determine the extent to which ALFs that furnish HCBS to Medicaid beneficiary residents comply with State licensure or certification requirements, we requested State survey agencies' inspection reports. From the database of Medicaid claims for the 7 States, we selected a simple random sample of 150 Medicaid beneficiaries (sampled beneficiaries) who resided in 141 ALFs and who received HCBS.<sup>43</sup> From the 7 States, we requested inspection reports for these 141 ALFs, receiving complete reports for 124 of them.<sup>44</sup> Our analysis thus includes 124 ALFs in which 133 of the sampled beneficiaries resided.

Plans of care developed by State Medicaid programs. To meet Federal plan of care requirements, State Medicaid programs—directly or through contact with other entities—develop a plan of care for each beneficiary who is eligible for HCBS. To determine whether plans of care were developed by the Medicaid programs<sup>45</sup> and whether they included (1) the documentation specified under the Federal requirements for HCBS and (2) the documentation specified by any additional requirements in the programs' approved 1915(c) waivers, we requested from the programs (and received) plans of care for the 150 sampled beneficiaries.

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<sup>42</sup> The timeframe for ALFs to submit claims varies among States. Therefore, to collect claims data from each State for a comparable 3-month period, we collected the data over the period of January through June 2009.

<sup>43</sup> Some ALFs had more than one resident Medicaid beneficiary.

<sup>44</sup> We tried to collect complete inspection reports for the remaining 17 of the 141 ALFs. However, the applicable Medicaid programs reported at the time of our review that additional information was not available. Therefore, we excluded the inspection reports for those 17 ALFs from our analysis.

<sup>45</sup> The plan of care could be developed by or on behalf of the Medicaid program.

Plans of care developed by ALFs. Medicaid providers, such as ALFs, independently develop their own plans of care for all residents. We conducted site visits to determine whether ALFs had the plans of care that are required by the State licensure or certification agencies. Specifically, we visited ALFs in our purposive sample of 7 States and reviewed the medical records of our 150 sampled beneficiaries.

### **Data Analysis**

Our findings are based on analysis of the data we collected from: (1) 35 Medicaid programs, (2) the State licensure or certification inspection reports associated with 133 of the 150 sampled beneficiaries, (3) plans of care from the Medicaid programs associated with the 150 sampled beneficiaries, and (4) plans of care from the ALFs associated with those 150 sampled beneficiaries. Our findings related to compliance with Federal requirements and State ALF licensure or certification requirements are projected to the population of beneficiaries (33,652) who resided and received HCBS in 4,811 ALFs in the 7 States. However, our findings related to compliance with Medicaid programs' additional documentation requirements in their waivers are not intended to be projected because those requirements do not apply to all of the seven States. The estimates and 95-percent confidence intervals for the statistics in this report are listed in Appendix A.

HCBS covered by State Medicaid programs. We analyzed State Medicaid program survey data from the 50 States to identify which programs covered HCBS for Medicaid beneficiaries residing in ALFs and to determine the annual cost of furnishing those HCBS.<sup>46</sup> We determined the latter by calculating the total annual cost that each State Medicaid program reported paying to ALFs for HCBS furnished to resident beneficiaries. Additionally, using the same survey data, we determined the number of beneficiaries who resided in ALFs and the number of ALFs that furnished HCBS to beneficiaries.

Documentation of provider standards. To determine whether provider standards existed in the 35 State Medicaid programs that covered HCBS in ALFs under 1915(c) waivers, we determined the number of States that provided documentation of their provider standards.

State licensure or certification inspection reports. We analyzed State survey agencies' inspection reports for the 124 ALFs associated with

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<sup>46</sup> To obtain the most current information regarding the number of Medicaid programs that covered HCBS in ALFs under the waiver, we collected this information directly from programs. For example, although 37 programs had approved waivers to cover HCBS in ALFs, only 35 programs had actual claims data or annual spending data for such HCBS during the time of our review.

133 of the sampled beneficiaries. We calculated the percentage of beneficiaries from the seven States who resided in ALFs that received at least one citation from survey agencies. We also determined the number of those ALFs that received citations for deficiency with regard to (noncompliance with) multiple State licensure or certification requirements governing the health and welfare of residents<sup>47</sup> or staff qualifications and training requirements.<sup>48</sup>

*Plans of care developed by State Medicaid programs.* To determine whether plans of care developed by State Medicaid programs for HCBS under the 1915(c) waiver included the documentation specified by Federal requirements, we reviewed the State-developed plans of care for the 150 sampled beneficiaries. This included determining the number of plans of care that identified:

- the medical and other services to be provided in ALFs,
- the expected frequency of these services, and
- the type of provider expected to furnish them.

Of the seven States, five had 1915(c) waivers that required Medicaid programs' plans of care to include additional documentation. We reviewed plans of care from these five States to determine whether they included this additional documentation. All five States had 1915(c) waivers requiring that plans of care include Medicaid beneficiaries' specific goals and the interventions to meet them.<sup>49</sup> In addition, two of the five States had waivers requiring that plans of care include the signatures of the beneficiaries (or their designated representatives) as an acknowledgment of the services and the conditions under which they are to be provided. We determined the number of plans of care that included the beneficiaries' specific goals and the interventions and the number of plans that included the signatures of the beneficiaries (or their designated representatives).

*Plans of care developed by ALFs.* To determine whether ALFs had developed the plans of care required for the sampled beneficiaries under State licensure or certification requirements, we reviewed 150 beneficiary

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<sup>47</sup> ALFs are subject to State agency inspection regardless of whether the residents are Medicaid beneficiaries.

<sup>48</sup> Although ALFs were cited for deficiencies in (i.e., noncompliance with) a variety of State licensure or certification requirements, we focused on deficiencies related to health and safety.

<sup>49</sup> "Goal" refers to the desired outcome of receiving the services outlined in the plan of care—for example, living independently. "Interventions" refer to the steps that the ALF will take if the beneficiary is not reaching the goal.

medical records during our onsite visits to ALFs. We then determined the number of records that included such plans.

**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.

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## FINDINGS

### **In 2009, 35 State Medicaid programs reported that they covered HCBS for beneficiaries in ALFs at an annual cost of \$1.7 billion**

Thirty-five State Medicaid programs covered a variety of HCBS for beneficiaries residing in ALFs at a total annual cost of \$1.7 billion.<sup>50</sup> These HCBS were furnished to more than 54,000 beneficiaries residing in approximately 12,000 ALFs. We visited different types of ALFs: private residences where beneficiaries were taken care of by relatives;<sup>51</sup> single-family homes that served 6 or fewer individuals; and multiunit residences, some of which served more than 200 individuals.

The HCBS covered included homemaker services, personal care services, and home health aide services. All 35 programs reported that their 1915(c) waivers cover homemaker services and personal care services. Twenty-five programs reported that their 1915(c) waivers also cover home health aide services.

Less than 10 percent of Medicaid beneficiaries who received HCBS under the 35 States' 1915(c) waivers resided in ALFs. The cost of those HCBS represented 12 percent of the total annual cost to furnish HCBS under the 1915(c) waiver. The average annual cost to furnish these services to beneficiaries residing in ALFs is approximately \$31,000 per beneficiary, compared to \$17,000 per beneficiary when the services are furnished in other settings. The disparity in costs may result from beneficiaries' receiving more HCBS when residing in ALFs. For example, beneficiaries residing in ALFs may receive HCBS 24 hours a day, whereas those services may be furnished on a limited basis in other settings, such as adult day health centers or senior day care centers.

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<sup>50</sup> This figure represents the total collective annual costs reported by 35 States during our period of review. Although two additional States also covered HCBS under their respective waivers, their waiver programs were in the early implementation stage and thus their annual costs to furnish HCBS were not yet available.

<sup>51</sup> In some States, Medicaid beneficiaries resided in their own homes or in their families' homes and received HCBS from family members. In most such cases, the beneficiary was a parent being taken care of by his/her child(ren).

**Provider standards existed in the 35 States; however, ALFs in the 7 States with the highest numbers of beneficiaries receiving HCBS in ALFs did not always comply with those standards, and plans of care did not always comply with Federal requirements**

State Medicaid programs provided assurances in their 1915(c) waiver applications that they had standards for all types of providers—including ALFs—that furnish HCBS under such waivers. Each of the 35 programs had established provider standards, as required, and ALFs were State licensed or certified as required. However, in the seven States that had the highest number of beneficiaries receiving HCBS via the 1915(c) waiver while residing in ALFs, most such beneficiaries were in ALFs that were cited for one or more deficiencies with regard to (i.e., instances of noncompliance with) State licensure or certification requirements. In addition, our review of beneficiary medical records and plans of care in the seven States found that the ALF-developed plans of care required under State licensure or certification requirements did not always exist. Furthermore, plans of care developed by State Medicaid programs did not always comply with Federal requirements or with the additional documentation requirements specified in the programs' respective approved 1915(c) waivers.

***Provider standards existed in each of the 35 States***

Provider standards existed in each of the 35 States that covered HCBS for Medicaid beneficiaries in ALFs. Each of the 35 Medicaid programs reported that, to comply with the Federal requirement that standards be established for providers furnishing HCBS under the 1915(c) waiver, the program uses the provider standards identified in its State licensure or certification requirements. As part of the ALF licensure or certification requirements, each State had specific standards for ALF employees based upon the type and level of care provided to the beneficiary. For example, to be licensed or certified as an ALF, a State may require that the ALF use only personal care attendants who have 40 hours of training and are State certified. The provider standards are part of the quality assurance measures that survey agencies verify during their inspections of ALFs.

***In the seven States, 77 percent of the Medicaid beneficiaries resided in ALFs that were cited for one or more deficiencies with regard to State licensure or certification requirements***

In the seven States, citations from survey agency inspections indicate that Medicaid programs covered HCBS furnished to resident beneficiaries in ALFs that did not comply with all State licensure or certification requirements. In 2009, 77 percent of beneficiaries receiving HCBS in



ALFs resided in ALFs that were cited for a deficiency with regard to (i.e., an instance of noncompliance with) at least one State licensure or certification requirement.<sup>52</sup> Sixty-eight percent of beneficiaries resided in ALFs that received multiple citations.

The types of deficiencies cited could compromise the health and welfare of the beneficiaries. For example, some of the deficiencies were related to “failing to furnish services outlined in residents’ plans of care” and “failing to dispense or administer medication as prescribed by a physician.” Table 1 lists the percentage of beneficiaries residing in ALFs cited for various deficiencies.

**Table 1: Percentages of Medicaid Beneficiaries in the Seven States Who Resided in ALFs Cited for Deficiencies<sup>53</sup>**

Types of Deficiency Citations That ALFs Received	Percentage of Resident Medicaid Beneficiaries
Failing to furnish services outlined in residents’ plans of care	23%
Failing to dispense or administer medication as prescribed by a physician	23%
Failing to complete initial assessments of residents	18%
Lacking a current plan of care for at least one resident	16%
Failing to ensure that staff had the required education and training prior to furnishing services to residents	16%
Failing to ensure that medication was administered by appropriately qualified staff	8%

Source: OIG analysis of seven States’ ALF inspection reports, 2010.

<sup>52</sup> A Medicaid beneficiary resided in each of these facilities. However, because residents of ALFs may consist both of Medicaid beneficiaries and nonbeneficiaries (i.e., private payers), citations issued to these ALFs may not directly apply to the care of a Medicaid beneficiary.

<sup>53</sup> The percentage of sampled beneficiaries exceeds 100 percent because a sampled beneficiary may have resided in an ALF that was cited for more than one type of deficiency.

***In the seven States, records for 9 percent of Medicaid beneficiaries receiving HCBS in ALFs did not include the required plans of care***

Independently of survey agencies' inspection reports, our onsite review of Medicaid beneficiaries' records in the seven States indicated that ALFs did not have required plans of care for all beneficiaries receiving HCBS in ALFs. Although all ALFs had records for each beneficiary, ALF-maintained records for 9 percent of beneficiaries in the seven States lacked plans of care as required by State licensure or certification requirements.<sup>54</sup> Of the records that lacked the required plans of care, 62 percent were from one State.

***In the seven States, the plans of care for 42 percent of Medicaid beneficiaries receiving HCBS in ALFs did not comply with the Federal documentation requirements***

Federal requirements for HCBS mandate that each plan of care developed by a State Medicaid program identify (1) the medical and other services to be provided, (2) their frequency, and (3) the type of provider to furnish them. In the seven States, we collected plans of care for sampled beneficiaries and reviewed them. This review found that each plan of care identified the type of HCBS to be furnished and the type of provider to furnish them. However, the plans of care for 42 percent of sampled beneficiaries did not include the frequency of HCBS to be furnished, as required. Of these plans of care, 73 percent were from one State.

***In five of the seven States, plans of care did not comply with the additional documentation requirements specified in the State Medicaid programs' approved 1915(c) HCBS waivers***

State Medicaid programs may specify additional documentation requirements in their approved HCBS 1915(c) waivers.<sup>55</sup> Of the seven States, five had waivers that specified that the plans of care would identify the beneficiaries' specific goals and the interventions to meet them. The purpose of this requirement is to ensure that beneficiaries receive the appropriate care. However, in those 5 States, plans of care developed by Medicaid programs for 69 of 105 sampled beneficiaries (66 percent) did not meet this requirement. Also, two of the seven States had waivers that

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<sup>54</sup> We could not determine whether a deficiency citation was directly related to HCBS furnished to a Medicaid beneficiary residing in the ALF. Therefore, we could not determine where the results from the State survey agency inspections were mutually exclusive of the results from our onsite reviews of the records of sampled beneficiaries.

<sup>55</sup> In States that have 1915(c) waivers that impose additional requirements, Medicaid programs must also meet these requirements to be considered in compliance with the Federal waiver requirements.

specified an additional requirement for the plans of care to be signed by beneficiaries or their representatives, as an acknowledgment of the services and the conditions under which they are to be provided. However, in those 2 States, plans of care for 12 of 25 beneficiaries (48 percent) receiving these services in ALFs did not meet this requirement.<sup>56</sup>

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<sup>56</sup> Our findings related to compliance with Medicaid programs' additional documentation requirements in their 1915(c) waivers are not intended to be projected because they do not apply to all seven of the States in our purposive sample.

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## RECOMMENDATION

During our period of review, 35 State Medicaid programs covered a variety of HCBS for Medicaid beneficiaries residing in ALFs at a cost of \$1.7 billion. Provider standards existed in each of the 35 States, and the ALFs were State licensed or certified, as required. However, some ALFs in the seven States with the highest numbers of beneficiaries receiving HCBS in ALFs were cited for deficiencies with regard to (i.e., noncompliance with) State licensure or certification requirements. Seventy-seven percent of beneficiaries in these seven States resided in ALFs that were cited for one or more deficiencies with regard to State ALF licensure or certification requirements, and 9 percent of the sampled beneficiaries' records did not include plans of care required under State licensure or certification. In addition, the plans of care for 42 percent of beneficiaries in the seven States did not include the frequency of HCBS to be furnished, as mandated by the Federal requirements. Furthermore, for 5 of the 7 States, 69 of 105 plans of care (66 percent) that we reviewed did not include the beneficiaries' goals and interventions as required by the States' approved 1915(c) waivers. For 2 of the 7 States, 12 of 25 plans of care (48 percent) we reviewed did not include appropriate signatures as required by the States' approved 1915(c) waivers.

We recommend that CMS:

### **Issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver**

Because waivers are broad and include a number of different settings in which providers furnish HCBS, guidance should be issued specific to HCBS furnished under the 1915(c) waiver to Medicaid beneficiaries in ALFs. CMS could issue a State Medicaid Directors' Letter emphasizing that Medicaid programs must meet assurances in their 1915(c) waivers to comply with Federal requirements for providers to furnish HCBS under the waiver. The guidance should address the assurances related to State licensure or certification requirements, Federal plan of care requirements, and any additional requirements specified in the programs' approved waivers.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, CMS concurred with our recommendation to issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver. CMS stated that it will issue guidance reminding States of their responsibilities in operating under all waivers and specifically those serving Medicaid beneficiaries residing in ALFs. However, on the basis of its initial analysis, CMS did not believe that such guidance would require a State Medicaid Directors' Letter, as OIG suggested.

CMS stated that by December 2012, it will review with its technical assistance contractors any opportunities to emphasize methods by which States may better comply with all requirements and will authorize them to do so. CMS also stated that in reviewing applications for waivers that cover HCBS for Medicaid beneficiaries in ALFs, it will immediately begin to examine quality measures for issues raised in this report.

We made technical corrections to the report on the basis of CMS's comments.

For the full text of CMS's comments, see Appendix B.

## APPENDIX A

### Confidence Intervals

Estimate Descriptions	Sample Size	Point Estimate	95-percent Confidence Interval
Medicaid beneficiaries residing in assisted living facilities (ALF) that were cited for one or more deficiencies with regard to (i.e., instances of noncompliance with) State licensure or certification requirements	133	77.4%	68.5%–83.5%
Beneficiaries residing in ALFs that received multiple citations	133	68.4%	59.7%–76.2%
Beneficiaries residing in ALFs that received citations for failing to furnish services outlined in residents' plans of care	133	22.6%	15.8%–30.6%
Beneficiaries residing in ALFs that received citations for failing to dispense or administer medication as prescribed by a physician	133	22.6%	15.8%–30.6%
Beneficiaries residing in ALFs that received citations for failing to complete an initial assessment	133	18.0%	11.9%–25.6%
Beneficiaries residing in ALFs that received citations for lack of current plans of care for at least one resident	133	15.8%	10.0%–23.1%
Beneficiaries residing in ALFs that received citations for failing to ensure that staff had the required education and training prior to furnishing services to residents	133	15.8%	10.0%–23.1%
Beneficiaries residing in ALFs that received citations for failing to ensure that medication was administered by appropriately qualified staff	133	7.5%	3.7%–13.4%
Medicaid beneficiaries receiving home and community-based services (HCBS) in ALFs that did not have the required plans of care	150	9.2%	4.2%–15.7%
Plans of care for Medicaid beneficiaries receiving HCBS in ALFs that did not comply with Federal documentation requirements	150	42.0%	33.9%–50.3%

Source: Office of Inspector General analysis of documentation review, 2010.

## APPENDIX B

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** SEP 25 2012

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Marilyn Tavenner */SI/*  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Home and Community-Based Services in Assisted Living Facilities" (OEI-09-08-00360)

Thank you for the opportunity to review and comment on the OIG draft report entitled, "Home and Community-Based Services in Assisted Living Facilities" (OEI-09-08-00360). The purpose of this report was to better understand Medicaid home and community-based services (HCBS) provided in assisted living facilities (ALFs), the cost associated with those services, and the extent to which those HCBS are furnished in compliance with federal and state requirements.

Under section 1915(c) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) may waive certain Medicaid requirements to enable state Medicaid programs to cover HCBS for individuals who have institutional levels of need. States may elect to offer 1915(c) waiver HCBS to Medicaid beneficiaries residing in ALFs. Medicaid does not reimburse for room and board; rather, it covers long-term care services and supports that ALF residents require.

#### OIG Findings

In 2009, 35 state Medicaid programs reported that — under the 1915(c) waiver authority — they covered a variety of HCBS for Medicaid beneficiaries in ALFs at an annual cost of \$1.7 billion. Provider standards existed in each of the 35 States as mandated by the federal requirements; however, OIG reports that ALFs in the seven states with the highest number of beneficiaries receiving HCBS in ALFs did not always comply with those standards, and plans of care did not always comply with federal requirements. In these seven states, 77 percent of 133 waiver enrollees sampled received HCBS under the 1915(c) waiver in ALFs that were cited for deficiencies with regard to at least one state licensure or certification requirement. Nine percent of 150 beneficiaries sampled had records that did not include plans of care required by the state licensure or certification requirements. Furthermore, 42 percent of the plans of care mandated by the federal requirements did not include the frequency of HCBS furnished, as required. Five of the seven states had specified additional optional requirements in the 1915(c) waiver for plans of care to identify the beneficiaries' specific goals and the interventions to meet those goals. In

these five states, 69 of 105 plans of care (66 percent) for beneficiaries receiving these services in ALFs did not meet that requirement. Two of the seven states had an additional 1915(c) waiver requirement for plans of care to be signed by beneficiaries or their representatives. In these two states, 12 of 25 plans of care (48 percent) for beneficiaries receiving these services in ALFs did not meet that requirement.

#### **OIG Recommendation**

The OIG recommends that CMS issue guidance to state Medicaid programs emphasizing the need to comply with federal requirements for covering HCBS under the 1915(c) waiver.

#### **CMS Response**

The CMS concurs that states must operate 1915(c) waivers according to all of the requirements of the approved waiver application, including the mandatory federal requirements for all waivers and any additional provisions included at the option of the state. CMS will issue guidance reminding states of their responsibilities in operating all waivers, and specifically those serving ALF residents. On initial analysis, we believe that the guidance would not be new policy of the kind that requires a state Medicaid Director letter.

The OIG findings touch on some mandatory requirements for which we have existing guidance, such as provider qualifications. We will review our guidance to determine whether additional clarity is needed, and whether we can offer some technical assistance to states in how to meet the present requirements. Technical assistance can be provided on a state by state basis. Other OIG findings relate to waiver operating procedures that are referenced, but not specified in detail, in the application, such as requirements for a facility to maintain a state license. The waiver application does not include all of the survey requirements a HCBS provider must meet in order to maintain the state license. For these issues, we can remind states of their responsibilities through national correspondence. By December 2012, CMS will review with our technical assistance contractors any opportunities to emphasize methods by which states may better comply with all requirements and will authorize them to do so.

We believe that since CMS began working on the development and implementation of a nationwide strategy of continuous quality improvements in 1915(c) waiver programs, our continuing development of quality improvement requirements in the 1915(c) waiver programs addresses the issues raised in this report. We have developed quality measurement and improvement methods in collaboration with state Medicaid agencies, waiver operating agencies, and their associations. Quality measures are very specific to each waiver. In reviewing applications for waivers offering services to residents of ALFs, we will immediately begin to examine the quality measures for issues raised in this report.



**Other Comments**

- a. In footnote 5, on page 2, the report states “HCBS may also be furnished in non-institutional settings such as . . . intermediate care facilities for individuals with intellectual and developmental disabilities.” As written, this statement may be misleading because it may be read to suggest that HCBS can be provided under the primary HCBS authority, section 1915, in an intermediate care facility for individuals with intellectual disabilities (ICF/ID). HCBS can be furnished under section 1915(c) of the Social Security Act (the Act) only to individuals who without such services would require the level of care provided in a hospital, nursing facility or *intermediate care facility for the mentally retarded* (ICF/MR). (Emphasis added.) (Pursuant to Public Law No. 111-256, references to and use of the term “mental retardation” should now be replaced with “intellectual disability.”). This language implies (and CMS has interpreted it to mean) that HCBS may not be provided to individuals residing in any of these statutorily enumerated settings, including intermediate care facilities for individuals with intellectual and developmental disabilities. Moreover, the various rules that propose to define the parameters of an HCBS setting explicitly provide that an ICF/MR is not a home or community setting. *See, e.g.,* the Community First Choice final rule, 77 Fed. Reg. 26828, 26850 (May 7, 2012). To avoid confusion about these settings being permissible settings under section 1915, please remove the language stating that HCBS may be provided in intermediate care facilities for individuals with intellectual and developmental disabilities.
- b. In the last sentence of the first paragraph, on page 6 (the paragraph starts on page 5), OIG describes the length of time for which a 1915(c) waiver may be approved. OIG says these waivers may be approved for 3 years, with a 5 year renewal. Section 2601 of the Affordable Care Act added section 1915(h)(2), which now allows CMS to approve 1915(c) waivers for 5 years if the waiver allows for dual eligibles to be enrolled and receive HCBS under the 1915(c) waiver. After this initial 5 year approval, the approval may be extended for an additional 5 years. With regards to this paragraph, please clarify that when a 1915(c) waiver allows for dual eligibles to receive HCBS under the waiver (including those waivers under which non-dual eligibles may also be enrolled), the waiver is approved for a 5 year period.

The CMS would again like to thank OIG for their efforts in reviewing Medicaid HCBS provided to residents of ALFs.

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## ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Loul Alvarez served as the team leader for this study, and Veronica Gonzalez served as lead analyst. Other Office of Evaluation and Inspections staff from the San Francisco regional office who conducted the study include Rob Gibbons, Camille Harper, Scott Hutchison, Christina Lester, and Marcia Wong. Central office staff who provided support include Kevin Farber, Kevin Manley, and Christine Moritz.

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# Office of Inspector General

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