



Highlights of [GAO-03-576](#), a report to congressional requesters

Why GAO Did This Study

Home and community-based settings have become a growing part of states' Medicaid long-term care programs, serving as an alternative to care in institutional settings, such as nursing homes. To cover such services, however, states often obtain waivers from certain federal statutory requirements. GAO was asked to review (1) trends in states' use of Medicaid home and community-based service (HCBS) waivers, particularly for the elderly, (2) state quality assurance approaches, including available data on the quality of care provided to elderly individuals through waivers, and (3) the adequacy of federal oversight of state waivers.

What GAO Recommends

GAO is recommending that the Administrator of CMS take steps to (1) better ensure that state quality assurance efforts are adequate to protect the health and welfare of HCBS waiver beneficiaries, and (2) strengthen federal oversight of the growing HCBS waiver programs. Although CMS raised certain concerns about aspects of the report, such as the respective state and federal roles in quality assurance and the potential need for additional federal oversight resources, CMS generally concurred with the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-03-576.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

LONG-TERM CARE

Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened

What GAO Found

From 1991 through 2001, Medicaid long-term care spending more than doubled to over \$75 billion, while the proportion spent on institutional care declined. Over a similar time period, HCBS waivers grew from 5 percent to 19 percent of such expenditures—from \$1.6 billion to \$14.4 billion—and the number of waivers, participants, and average state per capita spending also grew significantly. Since 1992, the number of waivers increased by almost 70 percent to 263 in June 2002, and the number of beneficiaries, as of 1999, had nearly tripled to almost 700,000, of which 55 percent were elderly.

In the absence of specific federal requirements for HCBS quality assurance systems, states provide limited information to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicaid program, on how they assure quality of care in their waiver programs for the elderly. States' waiver applications and annual reports for waivers for the elderly often contained little or no information on state mechanisms for assuring quality in waivers, thus limiting information available to CMS that should be considered before approving or renewing waivers. GAO's analysis of available CMS and state waiver oversight reports for waivers serving the elderly identified oversight weaknesses and quality of care problems. More than 70 percent of the waivers for the elderly that GAO reviewed documented one or more quality-of-care problems. The most common problems included failure to provide necessary services, weaknesses in plans of care, and inadequate case management. The full extent of such problems is unknown because many state waivers lacked a recent CMS review, as required, or the annual state waiver report lacked the relevant information.

CMS has not developed detailed state guidance on appropriate quality assurance approaches as part of initial waiver approval. Although CMS oversight has identified some quality problems in waivers, CMS does not adequately monitor state waivers and the quality of beneficiary care. The 10 CMS regional offices are responsible for ongoing monitoring for HCBS waivers. However, CMS does not hold these offices accountable for completing periodic waiver reviews, nor does it hold states accountable for submitting annual reports on the status of waiver quality. Consequently, CMS is not fully complying with statutory and regulatory requirements when it renews waivers. As of June 2002, almost one-fifth of waivers in place for 3 years or more had either never been reviewed or were renewed without a review; for an additional 16 percent of waivers, reports detailing the review results were never finalized. Regional office personnel explained that limited staff resources and travel funds often impede the timing and scope of reviews. While regional office reviews include record reviews for a sample of waiver beneficiaries, they do not always include beneficiary interviews. The reviews also varied considerably in the number of beneficiary records reviewed and their method of determining the sample.