



August 2017

MEDICAID MANAGED CARE

CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs

Accessible Version

GAO Highlights

Highlights of [GAO-17-632](#), a report to congressional requesters

Why GAO Did This Study

Twenty-two states use MLTSS programs to provide care for Medicaid beneficiaries who need long-term support. Using managed care to deliver long-term services and supports can be a strategy for states to expand home- and community-based care, which many beneficiaries prefer, and to lower costs. However, given the potential vulnerability and needs of beneficiaries in these programs, oversight is crucial to ensure their access to quality care.

GAO was asked to review states' implementation and CMS's oversight of MLTSS programs. In this report, GAO (1) described how selected states monitored MLTSS access and quality, and (2) examined the extent to which CMS oversees MLTSS access and quality in selected states.

GAO reviewed federal regulations, guidance, and internal control standards. For six states selected for variation in location, program size and duration, and other factors, GAO reviewed reporting requirements, reports to CMS, and other documents. GAO also reviewed data from these states on beneficiary appeals and grievances from 2013 through 2015—the most recent data available—and interviewed state and CMS officials.

What GAO Recommends

GAO recommends that CMS take steps to identify and obtain information to oversee key aspects of MLTSS access and quality, including network adequacy, critical incidents, and appeals and grievances. HHS concurred with GAO's recommendation.

View [GAO-17-632](#). For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

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CMS Should Improve Oversight Of Access And Quality In States' Long-Term Services And Supports Programs

What GAO Found

In Medicaid, long-term services and supports are designed to promote the ability of beneficiaries with physical, cognitive, or mental disabilities or conditions to live or work in the setting of their choice, which can be in home or community settings, or in an institution such as a nursing facility. States are increasingly delivering such services through managed care, known as managed long-term services and supports (MLTSS). In MLTSS, as with most Medicaid managed care programs, states contract with managed care organizations (MCO) to provide a specific set of covered services to beneficiaries in return for one fixed periodic payment per beneficiary. In addition, beneficiaries have the right to appeal an MCO decision to reduce, terminate, or deny their benefits, or file a grievance with an MCO regarding concerns about their care.

The six states GAO reviewed—Arizona, Delaware, Kansas, Minnesota, Tennessee, and Texas—used a range of methods for monitoring access and quality in MLTSS programs. To oversee beneficiaries' care, GAO found that states used—to varying levels—external quality reviews, beneficiary surveys, stakeholder meetings, and beneficiary appeals and grievances data. For example, while all six states used external quality reviews and beneficiary surveys, GAO found that states varied in the extent to which—and how—they used appeals and grievances data to monitor beneficiaries' concerns about quality and access in their MLTSS programs.

The Centers for Medicare & Medicaid Services (CMS)—the federal agency responsible for overseeing Medicaid—did not always require the six selected states to report the information needed to monitor access and quality in MLTSS programs. CMS primarily relied on its reviews of state-submitted reports to monitor MLTSS programs for compliance with federal regulations and state-specific reporting requirements, and what states are required to report to CMS can vary by state. Although CMS highlighted certain elements that it deemed essential to developing and maintaining high quality MLTSS programs in its 2013 guidance, GAO found that CMS did not require all selected states to report on these elements—namely, provider network adequacy; critical incidents, which are events that may cause abuse, neglect or exploitation of beneficiaries; and appeals and grievances. CMS did not require three of the six states that GAO reviewed to regularly report on network adequacy or provide summaries of critical incidents. Further, although CMS requires all selected states to report on their quality assurance efforts, GAO found that states often report general descriptions of their planned and ongoing quality assurance activities for MLTSS or their entire comprehensive managed care programs. Consequently, state reporting did not always provide CMS with information needed to assess state oversight of key elements. Gaps in reporting requirements may mean that CMS does not always have information needed to monitor key aspects of MLTSS access and quality among selected states and it may not be able to reliably detect state or MCO practices that do not meet CMS's guidance.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
EQRO	external quality review organization
HCBS	home- and community-based services
HHS	Department of Health and Human Services
MCO	managed care organization
MLTSS	managed long-term services and supports
SSI	Supplemental Security Income

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August 14, 2017

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Charles E. Grassley
United States Senate

In Medicaid, long-term services and supports are designed to promote the ability of beneficiaries with physical, cognitive, or mental disabilities or conditions to live or work in the setting of their choice, which can be in home or community settings, or in an institution such as a nursing facility.¹ States are increasingly delivering such services through managed care, known as managed long-term services and supports (MLTSS). In MLTSS, as with most Medicaid managed care programs, states contract with managed care organizations (MCO) to provide a specific set of covered services to beneficiaries in return for one fixed periodic payment per beneficiary—typically, per member per month.² As of May 2017, 22 states had enrolled beneficiaries in MLTSS programs and 5 additional states planned to implement such programs. In fiscal year 2015, the most recent year for which data were available, MLTSS accounted for an

¹Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of low-income people or persons with disabilities. States are required to cover care provided in an institution as part of Medicaid, but coverage of most care provided in the home or community is optional. Home- and community-based care includes, for example, personal care services and adult day care, which may allow beneficiaries to continue living in their homes. Personal care services assist beneficiaries with activities of daily living, such as bathing, dressing, and toileting. Adult day care refers to a variety of services and activities provided in a group setting within the community.

²States may have different types of managed care arrangements in Medicaid; in this report, we are referring to comprehensive, risk-based managed care, the most common type of managed care arrangement. MLTSS programs can also include prepaid inpatient health plans and prepaid ambulatory health plans. States have traditionally offered Medicaid long-term services and supports in fee-for-service programs. Fee-for-service is an approach to reimbursement in which state Medicaid agencies pay participating providers for each delivered service (e.g., an office visit, test, or procedure).

estimated \$29 billion of the \$158 billion in total Medicaid spending on long-term services and supports.³

Given the potential vulnerability and significant needs of the Medicaid beneficiaries who use long-term services and supports, federal and state oversight of MLTSS programs is crucial for ensuring their access to quality care—that is, the provision of health care services that promote desired health outcomes and are consistent with current professional knowledge.⁴ The types of beneficiaries eligible for MLTSS programs vary by state, but can include the elderly; adults with physical, intellectual, or developmental disabilities; and children with disabilities. These beneficiaries may have limited ability to care for themselves, and may need support such as nursing care or assistance with eating or dressing. Many beneficiaries prefer to receive support in home- and community-based settings, and MLTSS programs can be a strategy for states to expand access to home- and community-based care, potentially at a lower cost than institutional care.⁵ MLTSS programs can also provide an opportunity for states to better integrate Medicaid long-term services and supports with acute care or other services.⁶ At the same time, however, the use of managed care to meet MLTSS beneficiaries' needs assumes that the provision of appropriate services can be achieved in a cost-effective manner for a population that is among the most vulnerable and has particularly high health care needs.

³This reflects both federal and state spending on Medicaid. See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015* (April 14, 2017). Due to challenges with collecting MLTSS data, Truven Health Analytics reported that this is a conservative estimate of overall MLTSS expenditures.

⁴The Institute of Medicine defines quality of care as the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” See Institute of Medicine, *Medicare: A Strategy for Quality Assurance, Volume I* (Washington, D.C.: 1990).

⁵Increasing the availability of community-based care is also important for states to be able to comply with the Supreme Court’s 1999 decision in *Olmstead v. L.C.*, in which the Court held that unjustified institutionalization of a person based on disability violates Title II of the Americans with Disabilities Act. *Olmstead v. L.C.*, 527 U.S. 581 (1999). In particular, the Court held that states must provide community-based care for persons with disabilities who are otherwise entitled to institutional services when such services are appropriate, the individual does not oppose such treatment, and the community-based care can be reasonably accommodated, taking into account the resources available to a state and the needs of others with disabilities.

⁶States may, for example, choose to have MCOs provide MLTSS as part of a broader, comprehensive managed care program that also provides acute care or behavioral health care.

As with Medicaid generally, the states and the Centers for Medicare & Medicaid Services (CMS)—within the Department of Health and Human Services (HHS)—share responsibility for overseeing MLTSS programs, including monitoring beneficiaries’ access to and quality of care. States are responsible for the operation of MLTSS programs and for monitoring the MCOs that provide the care. CMS is responsible for approving and monitoring states’ MLTSS programs to ensure that they comply with all applicable federal requirements. For example, among other beneficiary protections to help ensure access to care, MLTSS beneficiaries have the right, by law, to appeal an MCO’s decision to reduce, terminate, or deny payment for services, such as a decision to deny coverage for a specific service or reduce the hours of MLTSS services. MLTSS beneficiaries may also file a grievance with an MCO about their care, such as to express dissatisfaction about difficulty getting an appointment with an MLTSS provider or concerns about the quality of MLTSS care. In addition, CMS may set state-specific requirements for an individual MLTSS program, which are generally known as special terms and conditions. For example, in state programs’ special terms and conditions, CMS may establish reporting requirements in which states must periodically report to CMS on specific aspects of their MLTSS programs, such as on measures of access to care or quality.

You asked us to provide information on how states are implementing MLTSS and on CMS oversight of MLTSS programs. In January 2017, we issued a report that examined how selected states structured financial incentives in their MLTSS programs and CMS’s policies and procedures for overseeing states’ payment structures.⁷ In this report, we

1. describe how selected states monitored access and quality in their MLTSS programs, including their use of beneficiary appeals and grievances; and
2. examine the extent to which CMS oversees MLTSS access and quality in selected states.

To describe how states monitored access and quality in their MLTSS programs, including their use of beneficiary appeals and grievances, we reviewed selected states’ documentation of their MLTSS monitoring efforts as well as relevant federal regulations and guidance regarding state oversight. Out of the 21 states with established MLTSS programs as

⁷GAO, *Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports*, [GAO-17-145](#) (Washington, D.C.: Jan. 9, 2017).

of calendar year 2013, we selected 6 states—Arizona, Delaware, Kansas, Minnesota, Tennessee, and Texas—whose MLTSS programs were authorized under a section 1115 demonstration or section 1915 waiver and reflected a range of experiences in terms of the length of time they had been in place; the number of beneficiaries receiving MLTSS in fiscal year 2013; the percentage of MLTSS spending on services provided in the home and the community—referred to as home- and community-based services (HCBS)—in fiscal year 2013; and geographic region.⁸ The fiscal year 2013 data on MLTSS programs and their number of beneficiaries and spending were the most recently available state-level data at the time we selected states for review. The 6 states represented over 30 percent of all Medicaid beneficiaries in MLTSS programs as of July 2015. We collected information on the methods these states used to monitor access and quality in MLTSS programs, such as quality improvement strategies and external reviews, and examined states' uses of beneficiary appeals and grievances. We reviewed documentation, such as state contracts with MCOs—which specify what services MCOs are required to provide and what information MCOs are required to report to the state, among other responsibilities—and state quality strategies. We also reviewed state data on beneficiaries' appeals and grievances and states' compliance actions in calendar years 2013 through 2015, and the outcomes of beneficiaries' appeals for calendar year 2015. We interviewed state Medicaid officials about their monitoring efforts, and discussed state oversight with CMS officials. Neither the MLTSS programs in these six states nor the methods they use to monitor access and quality that we examined are generalizable to other states.

To examine the extent to which CMS oversees MLTSS access and quality in selected states, we reviewed documents regarding CMS's monitoring efforts, including Medicaid managed care regulations and CMS guidance on MLTSS programs. In addition, for our 6 selected states, we reviewed their MLTSS special terms and conditions, including

⁸Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. Section 1915(b) provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. States that use section 1915(b) waivers to implement MLTSS programs may also have a concurrent, separate authority such as section 1915(c) waivers. Specifically, states use section 1915(b) waivers to mandate enrollment in managed care and use section 1915(c) waivers to target eligibility and provide certain community-based care in their MLTSS programs.

CMS's reporting requirements regarding MLTSS access to and quality of care, and examined the variation in those requirements across states. We focused on states' reporting requirements related to the section 1115 and 1915 demonstrations and waivers, the most commonly used authorities for MLTSS programs. We also reviewed the states' quarterly and annual reports to CMS about their MLTSS programs, and assessed whether those reports were consistent with CMS's state-specific reporting requirements. We also interviewed CMS and state officials about MLTSS monitoring and oversight efforts. We assessed CMS's monitoring efforts using agency guidance that lists key elements of effective MLTSS programs, which CMS uses to review state applications for new MLTSS programs as well as existing MLTSS programs.⁹ For our analysis, we focused on a subset of key elements that were directly related to access and quality of care, and could be reviewed in the context of state reporting requirements. We also considered the extent to which CMS's monitoring efforts are consistent with relevant *Standards for Internal Controls in the Federal Government*, specifically, those related to monitoring.¹⁰ In addition, we interviewed officials with HHS's Administration for Community Living, which is responsible for increasing individuals' access to community supports.

We conducted this performance audit from September 2015 to August 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁹Centers for Medicare & Medicaid Services, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs* (2013).

¹⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

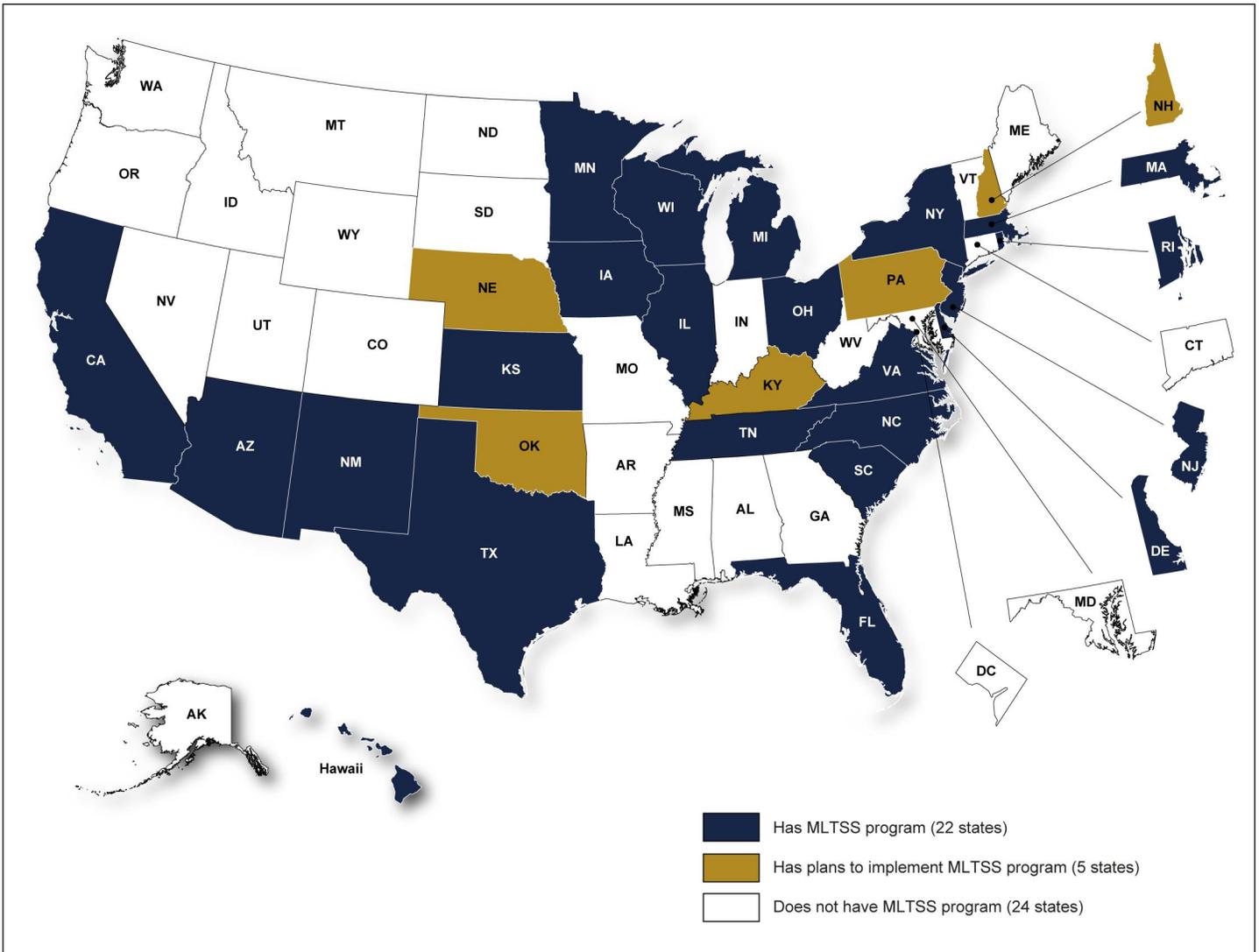
Background

Prevalence and Characteristics of Medicaid Managed Long-Term Services and Supports Programs

States' increasing use of managed care for Medicaid beneficiaries needing long-term services and supports is a significant change from how states have historically met the needs of these vulnerable populations. While many states have extensive experience with using managed care programs to provide physical or behavioral health care services, states have not typically included beneficiaries needing long-term care services—especially seniors and adults with physical or developmental disabilities—in managed care programs. In 2004, only 8 states had implemented MLTSS programs. In contrast, as of May 2017, 27 states either had implemented MLTSS programs or were planning to implement them. (See fig. 1.) The most recent enrollment data available at the time of our study, from July 2015, showed that MLTSS programs in 18 states collectively served around 1 million Medicaid beneficiaries that year.¹¹

¹¹This reflects CMS's estimate of the total number of MLTSS users, and does not include beneficiaries who were enrolled in a MLTSS program but did not actually receive any long-term services and supports. See Centers for Medicare & Medicaid Services and Mathematica Policy Research, *Medicaid Managed Care Enrollment and Program Characteristics, 2015* (2016).

Figure 1: States with Current or Planned Managed Long-Term Services and Supports (MLTSS) Programs, May 2017



Source: GAO summary of Centers for Medicare & Medicaid Services information; Map Resources (map). | GAO-17-632

Long-term services and supports include a broad range of health and health-related services and non-medical supports for individuals who may have limited ability to care for themselves because of physical, cognitive, or mental disabilities or conditions—and who need support over an extended period of time. Individuals needing long-term services and supports have varying degrees of difficulty performing activities of daily living, such as bathing, dressing, toileting, and eating, without assistance. They may also have difficulties with preparing meals, housekeeping,

using the telephone, and managing money. Long-term services and supports to address these needs are generally provided in two settings: institutional facilities, such as nursing facilities and intermediate care facilities for individuals with intellectual disabilities; and home and community settings, such as individuals' homes or assisted living facilities. HCBS cover a wide range of services and supports to help individuals remain in their homes or a community setting, such as personal care services to provide assistance with activities of daily living.¹²

MLTSS programs can vary due in part to the flexibility that Medicaid allows states in establishing their programs. For example, states have flexibility in determining which populations to include in their MLTSS programs and whether to use mandatory or voluntary enrollment.¹³ States also have flexibility in determining what services to include. In addition, states may choose to have MLTSS as part of a broader, comprehensive managed care program that also provides acute care or behavioral health care, or to have MLTSS as a separate managed care program. See table 1 for characteristics of MLTSS programs in the six states we selected for review. (App. I provides more information on the MLTSS programs in our selected states.)

¹²HCBS can also include adult day care services and activities provided in a group setting within the community; certain home modifications that allow the beneficiary to remain in the home; and non-medical transportation.

¹³For example, states may include older adults, individuals with physical disabilities, and individuals with intellectual or developmental disabilities in their MLTSS programs. States may limit some of these populations to adults only or may include both children and adults.

Table 1: Characteristics of Managed Long-Term Services and Supports (MLTSS) Programs in Selected States

Types of beneficiaries receiving MLTSS, 2015								
State	Number of beneficiaries receiving MLTSS, 2015	Seniors	Adults with physical disabilities	Adults with intellectual and developmental disabilities	Children with disabilities	Mandatory or voluntary enrollment, 2015	Number of MCOs under contract, 2015	
Arizona	55,475	yes	yes	yes	yes	Mandatory	Three MCOs One state agency	
Delaware	6,340	yes	yes	no	yes	Mandatory	Two MCOs	
Kansas	33,255	yes	yes	yes	yes	Mandatory ^a	Three MCOs	
Minnesota	33,185	yes	yes (over age 65)	yes (over age 65)		Mandatory for some beneficiaries, voluntary for others ^b	Seven MCOs	
Tennessee	30,166	yes	yes	yes	no	Mandatory	Three MCOs	
Texas	97,914	yes	yes	no	yes	Mandatory for some beneficiaries, voluntary for others ^c	Five MCOs	

Key: MCO means managed care organization.
Source: GAO analysis of state-reported data. | GAO-17-632

Notes: Beneficiary data are as of December 2015 for Arizona, Delaware, Kansas, and Tennessee. For Minnesota, data represent full-year equivalents based on member months for calendar year 2015, and for Texas, data represent average monthly enrollment for calendar year 2015 with estimated data after August 2015.

^aIn Kansas, the population of American Indians could opt out of mandatory enrollment.

^bIn Minnesota, enrollment was mandatory for the Minnesota Senior Care Plus program and voluntary for the Minnesota Senior Health Options program, which serves beneficiaries who are dually eligible for both Medicaid and Medicare. Enrollees who disenroll from the Minnesota Senior Health Options program were subject to mandatory enrollment in the Minnesota Senior Care Plus program.

^cIn Texas, for example, enrollment was mandatory for adults receiving Supplemental Security Income (SSI)—a Social Security Administration program that provides benefits for disabled, blind, or aged people who have low income and limited resources—and voluntary for children and young adults under age 21 who received SSI and SSI-related Medicaid benefits.

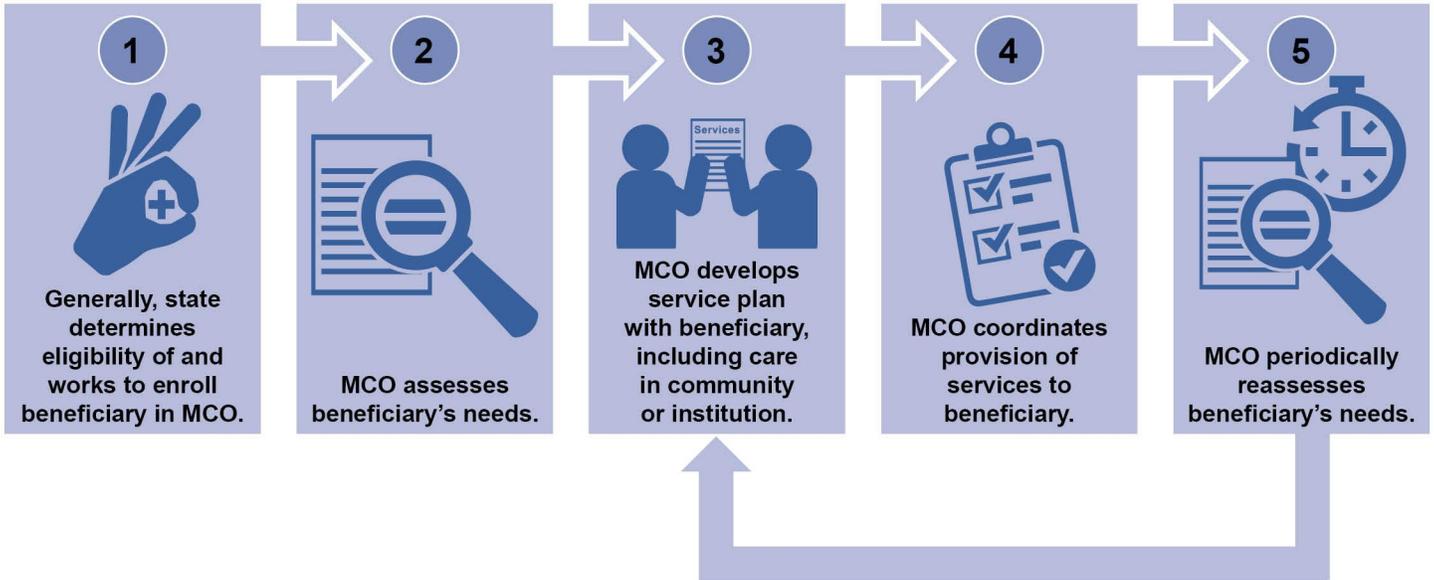
Delivery of MLTSS and State Oversight

Within MLTSS programs, MCOs are responsible for coordinating the delivery of services to beneficiaries. To be eligible for MLTSS, beneficiaries must meet income and asset requirements, and also meet

state-established criteria on the level of care needed, such as needing an institutional level of care.¹⁴ Once a person is determined eligible, the individual can be enrolled to receive MLTSS from an MCO. The MCO then works with the beneficiary to develop a service plan that addresses the beneficiary's needs and preferences, including determining the type and amount of services the beneficiary needs. (See fig. 2.) For example, for a beneficiary receiving care in the home, the MCO determines if personal care services are needed and, if so, the amount of services, such as the number of hours needed per week. The MCO is then responsible for implementing this service plan and coordinating the beneficiary's care.

¹⁴To determine who meets criteria on level of care, states may use functional criteria (e.g., the extent to which a person needs assistance with activities of daily living), clinical criteria, or a combination of the two. Eligibility requirements also apply for long-term services and supports provided under fee-for-service.

Figure 2: Managed Care Organizations' (MCO) Role in Coordinating Services for Beneficiaries in Managed Long-Term Services and Supports (MLTSS) Programs



- 1** The state, or an independent entity, determines eligibility and works with the beneficiary to enroll in an MCO. To be eligible for MLTSS, a beneficiary must meet state-established criteria on the level of care needed, such as needing an institutional level of care.
- 2** The MCO assesses the beneficiary's physical, functional, and psychosocial needs such as health status, treatment needs, and preferences for care. These also include social, employment, and transportation needs and preferences.
- 3** The MCO is responsible for developing/revising a service plan through a process that actively engages the beneficiary and individuals of choice. The service plan must address how a combination of covered services and available community supports will meet the beneficiary's or caregiver's needs and preferences, including preferences for receiving care in the community or in an institution.
- 4** The MCO coordinates the provision of all services to the beneficiary. Services may include MLTSS—both community-based and institutional services—as well as physical and behavioral health services.
- 5** The MCO reassesses the beneficiary's needs at least every 12 months, after a significant change in the beneficiary's needs or circumstances, or at the request of the beneficiary.

Source: GAO analysis of Centers for Medicare & Medicaid Services regulations and guidance. | GAO-17-632

Although MCOs are responsible for coordinating MLTSS beneficiaries' care, states remain responsible for the operation of MLTSS programs and must monitor the MCOs. State contracts establish MCO responsibilities with respect to the services the MCO is responsible for providing, the beneficiary protections that must be in place, and the information the MCO must report to the state. States then monitor MCO actions for compliance with contractual requirements. States may take compliance actions if they find that MCOs are not complying with contractual requirements and if they identify issues with MCOs' provision of care. Compliance actions range in severity and can include informing MCOs of problems through letters or notices, issuing corrective action plans for the MCO to implement, or assessing intermediate sanctions.

Federal Role in MLTSS Programs

States are required to seek CMS approval for their MLTSS programs, which they can implement through several different authorities. Among the most commonly used authorities are section 1115 demonstrations and section 1915(b) waivers. Before approving an MLTSS program, CMS works with the state to shape the program design, including how the program will align with CMS guidance. In 2013, CMS issued guidance that set expectations for states seeking approval of MLTSS programs through section 1115 demonstrations or section 1915(b) waivers.¹⁵ In particular, CMS listed 10 key elements of effective MLTSS programs that the agency expects states to incorporate into both new and existing MLTSS programs.¹⁶ These elements address a range of topics, including qualified providers (or network adequacy), participant protections (including appeals and grievance processes and a critical incident management system with safeguards to prevent abuse, neglect, and exploitation), and quality (implementation of a comprehensive quality strategy for MLTSS). For example, states must ensure that MCOs maintain a network of qualified long-term services and supports providers that is sufficient to provide adequate access to covered services; establish safeguards to ensure beneficiary health and welfare; and develop mandatory MCO reports on MLTSS quality of care performance measures, analyze those reports, and take corrective actions if needed. CMS's guidance noted that if a state incorporated these 10 elements it would increase the likelihood of having high-quality MLTSS programs. CMS uses these elements to review and approve states' MLTSS programs.

¹⁵See Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (2013). This guidance was intended to share what CMS learned from states, stakeholders, and advocates about best practices for establishing and implementing MLTSS programs—and to clarify CMS's expectations for states using these authorities in an MLTSS program. According to the guidance, MLTSS program designs, written contracts, program operations manuals, and other documents governing the relationship between a state and its managed care plans must incorporate this guidance, as well as statutory and regulatory requirements.

¹⁶The 10 elements are (1) adequate planning, (2) stakeholder engagement, (3) enhanced provision of HCBS, (4) alignment of payment structures and goals, (5) support for beneficiaries, (6) person-centered processes, (7) comprehensive integrated service package, (8) qualified providers, (9) participant protections, and (10) quality.

When CMS approves an MLTSS program under a section 1115 demonstration or section 1915 waiver, it establishes state-specific requirements for the program and also specifies how it will oversee the program on an ongoing basis.¹⁷ For example, CMS may require a state to conduct specific MCO monitoring activities. In addition, CMS may require a state to submit quarterly and annual performance reports to CMS. These reports may address state-specific measures of quality and access, including information on appeals and grievances. Within CMS, oversight of MLTSS programs is a joint responsibility of the agency's central and regional offices.

In addition to state-specific requirements, states with MLTSS programs are also subject to broader quality requirements that apply to all Medicaid managed care programs. For example, states must have an external quality review process to assess the quality of care MCOs provide to all managed care beneficiaries, including MLTSS beneficiaries. States may use an external quality review organization (EQRO)—an independent organization specializing in external quality reviews—to conduct several required external quality review activities, and must use an EQRO for an annual quality review.¹⁸ States must also have a quality strategy for MLTSS programs that includes, for example, a discussion of performance measures, performance improvement projects, and state quality oversight plans. Changes to requirements for states regarding Medicaid managed care quality are slated to take effect in July 2017 or later, under CMS's 2016 Medicaid managed care final rule, which was the first major change to Medicaid managed care regulations since 2003.¹⁹

¹⁷CMS documents its state-specific oversight process in the special terms and conditions that represent the agreement between CMS and the state about the MLTSS program.

¹⁸Specifically, states have the option to use an EQRO for required external quality review activities, including (1) a review of MCO compliance with state requirements, (2) validation of performance measures, and (3) validation of performance improvement projects. States must also ensure that each year an EQRO reports to the state on aspects of the quality of care provided by MCOs. According to CMS, states often use their EQRO to conduct optional quality activities. CMS's optional quality activities include, for example, calculating additional performance measures, administering or validating surveys, and conducting studies of particular aspects of health care quality.

¹⁹Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498 (May 6, 2016).

Beneficiary Appeals and Grievance Processes

The beneficiary appeals and grievance processes are important beneficiary protections for MLTSS programs. By law, MCOs must have an internal appeals process in place so that MLTSS beneficiaries may challenge certain MCO actions, such as decisions to terminate services, as well as a process for MLTSS beneficiaries to file a grievance with the MCO regarding their care.²⁰

Appeals. A beneficiary can file an appeal in response to an MCO's decision to, among other things, reduce services, terminate services, or deny payment for services.²¹ For example, a beneficiary could appeal an MCO's decision to deny coverage for a specific type of MLTSS care, such as personal care services, or to reduce the number of personal care attendant hours a beneficiary will receive. After the beneficiary submits an appeal, the MCO will either approve the appeal (meaning that the MCO, through its internal appeals process, overturns its original decision and resolves the appeal in favor of the beneficiary), or deny the appeal (meaning that the MCO upholds its original decision). If an MCO denies the appeal, the beneficiary can request that the state review the MCO's decision through the state's fair hearing process, in which state officials rule on whether the MCO's decision should be upheld.

Grievances. A beneficiary can file a grievance with an MCO to express dissatisfaction about any matter not covered by appeals. For example, a beneficiary could file a grievance about difficulty getting an appointment with an MLTSS provider, concerns about the quality of MLTSS care, a provider or MCO not respecting a beneficiary's rights, or a provider not treating the beneficiary respectfully. Beneficiaries may also submit grievances directly to the state, in a manner determined by the state, such as to the state Medicaid agency or state long-term care ombudsman.²² After receiving information about the beneficiary's

²⁰42 U.S.C. § 1396u-2(b)(4).

²¹In the event of such an action, MCOs are required to send beneficiaries a notice including information about the beneficiary's right to file an appeal and how to do so. 42 C.F.R. § 438.404 (2016).

²²Each state has a long-term care ombudsman program that provides assistance for residents of nursing homes, assisted living facilities, and other types of facilities by working to resolve problems raised by residents or their families. These state programs can assist Medicaid beneficiaries as well as individuals who are not covered by Medicaid.

grievance, the MCO conducts an independent review and determines what, if any, steps are needed to resolve the grievance.

Appeals and grievances processes are slated to change, beginning in July 2017, due to changes specified in CMS's May 2016 Medicaid managed care final rule.²³ For example, there is a new requirement that MCOs maintain records about each grievance or appeal, including a general description of the reason for the appeal or grievance, the date received and reviewed, and the resolution at each level of the grievance or appeal. MCOs must maintain these records in a manner accessible to the state and provide them to CMS upon request.²⁴ Previously, states have been required to maintain information on appeals and grievances, and the final rule specified what those records must include.

²³Managed care appeals and grievances regulations are set forth at 42 C.F.R. pt. 438, subpt. F.

²⁴There is also a new requirement for beneficiaries to exhaust the MCO appeals process prior to initiating the state's fair hearing process, which is a change for states that have allowed the state fair hearing process to occur concurrently with the MCO appeals.

Selected States Used Multiple Methods to Oversee MLTSS Care, and Varied in the Extent to Which They Used Beneficiary Appeals and Grievances to Monitor Access and Quality

Selected States Used a Range of Methods, Including External Reviews, to Oversee MLTSS Access and Quality

The six states we reviewed used a range of methods to oversee MLTSS beneficiaries' access to and quality of care. States' oversight methods included implementing external quality reviews, tracking performance measures, surveying beneficiaries, and reviewing medical charts, among other activities. In some cases, these oversight methods were specific to MLTSS programs, while in other cases the methods addressed MLTSS as well as other state managed care programs. Examples of state oversight methods included the following:

External quality reviews: All six states implemented the external quality reviews that CMS requires, which involves assessments of MCOs' compliance with requirements related to quality, and validating MCO performance measures and performance improvement projects. In each of these states, the state's EQRO assessed MCO compliance with quality requirements and reported to the state on their findings. Examples of EQROs' findings included:

- The Texas EQRO 2014 report found weaknesses in the state's performance measures on effectiveness of care and made recommendations to the state to improve the care provided through the state program that provides both MLTSS and acute care for elderly beneficiaries. These included steps to improve performance on measures such as the rates of potentially preventable hospital admissions and emergency department visits.
- The Delaware EQRO assessed aspects of quality and access across the two MCOs that operated both MLTSS and non-MLTSS services. The EQRO's 2014 report to the state reported, for example, that both plans were compliant with Medicaid managed care regulations regarding quality assessment and performance improvement, but that they could improve in managing the grievance and appeals process, and ensuring appropriate resolution and communication with beneficiaries and providers.

In addition to required EQRO reviews, five of the six states reported that they had their EQROs conduct other quality oversight activities. For example, Delaware's EQRO took part in a task force that provides a forum for sharing best practices, and identifies and implements quality improvement strategies. Tennessee contracted with its EQRO to prepare an annual report on national initiatives that may affect managed care, and conduct educational meetings for state quality staff and MCOs.

Use of MCO performance measures and beneficiary surveys: All six states tracked performance measures, which varied by state, but included measures such as rates of hospitalization, timely MCO response to beneficiary grievances, and the proportion of beneficiaries receiving certain services. For example, Texas tracked the proportion of grievances that were resolved within certain time frames, and Kansas tracked the proportion of beneficiaries receiving HCBS care who received a flu vaccine. The states also used beneficiary surveys to help monitor MLTSS care. For example, one state's survey asked beneficiaries about their satisfaction with and ability to access services. States generally used surveys that were designed by the state or by their EQRO.²⁵ The states used established surveys, or incorporated questions from established surveys, such as the National Core Indicators—Aging and Disability survey and the Consumer Assessment of Healthcare Providers & Systems in their surveys.

Reviews of beneficiary information such as medical charts or case files: Five of the six states reported that they had efforts to review or audit MLTSS beneficiary information, such as medical charts, case files, or other information, to identify potential issues with MLTSS care. The frequency of their efforts ranged from quarterly to once every 3 years. For example, Arizona conducted medical chart reviews at least every 3 years, reviewing a sample of charts for MCO compliance with case management requirements in areas such as timeliness, assessments of care, and the services provided to beneficiaries. Delaware conducted quarterly on-site reviews, which included reviews of beneficiaries' case files, level of care assessments, and each MCO's critical incident management system, to

²⁵In some cases, the EQROs conducted and analyzed the surveys as part of their work for the state.

ensure that beneficiaries were receiving necessary services and that MCOs were complying with requirements regarding MLTSS care.²⁶

Reviews of provider networks: Officials in all six states reported conducting their own assessments of MLTSS provider networks or requiring MCOs to report on their MLTSS provider networks.²⁷ Kansas, for example, conducted provider network adequacy assessments and annual audits about access. Minnesota, every 2 years, surveys geographic areas to identify provider gaps, and assesses provider networks and providers' ability to deliver services; it shares information on any identified provider gaps with its MCOs. Arizona required MCOs to submit an annual plan about provider network development, including information on any network gaps, and to report any changes in networks which would affect more than five percent of beneficiaries within one geographic service area.

Stakeholder meetings: Officials in all six states told us that they met with stakeholders, such as state long-term care ombudsmen, beneficiary advocates, or providers, on a regular basis to discuss beneficiaries' experiences with MLTSS care.

²⁶Critical incidents are events or situations that cause or may cause harm to a beneficiary's health or welfare, such as abuse, neglect, or exploitation.

²⁷Some states reported that their efforts were part of broader efforts to assess MCO provider networks, including MLTSS and non-MLTSS providers.

Selected States Varied in the Extent to Which They Used Appeals and Grievances to Monitor Beneficiaries' Concerns about MLTSS Access and Quality

The six states we reviewed varied in the extent to which—and how—they used appeals and grievance data to monitor beneficiaries' concerns about quality and access in their MLTSS programs. We found variation, for example, in the extent to which states were collecting and using data on appeals and grievances specifically related to MLTSS care, calculating appeals and grievance rates, and monitoring the outcomes of beneficiaries' appeals.

Collecting and using MLTSS-specific data: Two of the six states—Arizona and Texas—did not separate MLTSS appeals and grievances from those related to other managed care services or beneficiaries. In these two states, MCOs that provide MLTSS also provide non-MLTSS services, such as acute care.²⁸ While both states collected and used data on managed care appeals and grievances, they did not require MCOs to report MLTSS appeals and grievances separately from those for other managed care services and beneficiaries, or in a way that allowed the states to identify all MLTSS-specific appeals and grievances.²⁹ In the other four states—Delaware, Kansas, Minnesota, and Tennessee—the MCOs reported MLTSS appeals and grievances separately from appeals and grievances related to other managed care services and beneficiaries.³⁰ Within these four states, monitoring practices varied. Officials in one of these four states, for example, reviewed monthly

Example of One State's Use of Managed Long-Term Services and Supports Program-Specific Appeals and Grievance Data

Officials in one state learned through beneficiary appeals, complaints to the state, and threats of legal action that a managed care organization had reduced the hours of private duty nursing services provided to some beneficiaries without first conducting face-to-face meetings between the care coordinator and individual beneficiaries about the beneficiaries' coordination of care. The state took action in response to these findings.

Source: GAO summary of state information. | GAO-17-632

²⁸In Arizona, several MCOs provide MLTSS as a part of comprehensive managed care services that also include covered non-MLTSS services, such as acute care and behavioral health. In this state, MCOs reported appeals and grievances filed by beneficiaries receiving MLTSS care, but the data did not distinguish which appeals and grievances were specifically related to MLTSS and which were related to non-MLTSS care. In Texas, MCOs that provide comprehensive managed care services inclusive of MLTSS also serve beneficiaries who receive only acute care services. In this state, MCOs reported appeals in a manner that did not distinguish MLTSS beneficiaries from beneficiaries who did not receive MLTSS care—or distinguish MLTSS services from non-MLTSS services.

²⁹According to CMS officials, these two states were fulfilling related regulatory requirements even though they were not able to separate MLTSS appeals and grievances from other appeals and grievances.

³⁰For example, Minnesota used service categories for nursing facility and home- and community-based services to distinguish MLTSS appeals and grievances from those for other populations.

reports on MLTSS appeals. They said appeals data helped them understand what was happening with beneficiaries on a regular basis, identify any systemic patterns in appeals, and take action if needed. They also noted that, as one way of measuring access to care, they review appeals and grievance data for any beneficiary complaints about not having access to providers. In Kansas, officials said that they regularly reviewed appeals and grievances separately for all beneficiaries receiving HCBS; they reviewed appeals and grievances for beneficiaries receiving MLTSS care in a nursing facility as part of their review of the state's broader managed care population.³¹

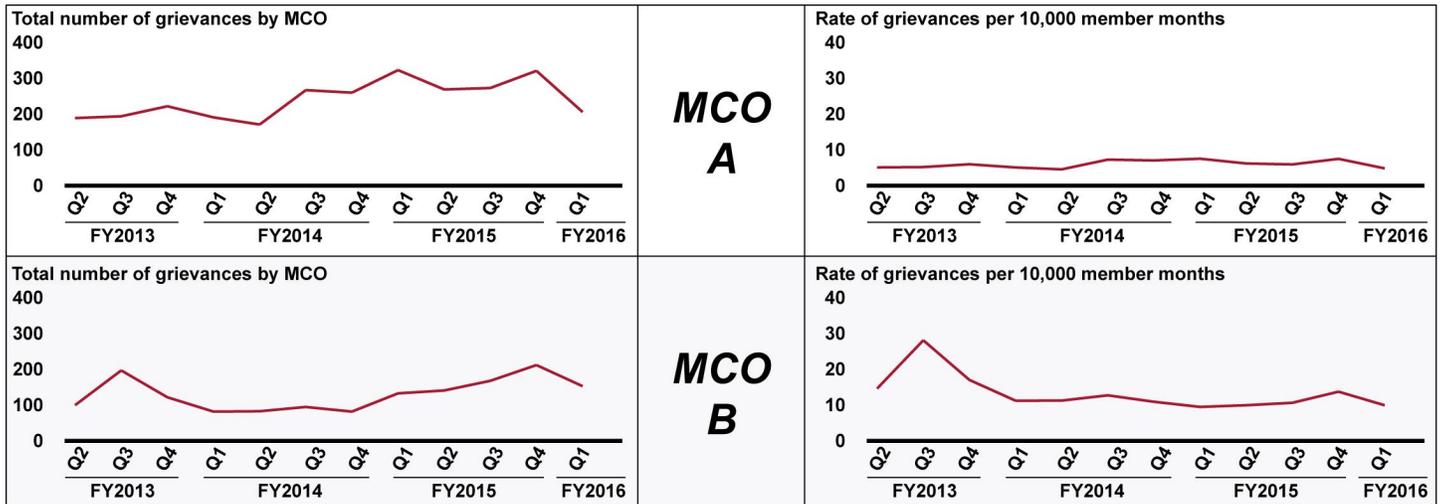
Calculating appeals and grievances rates: Three states—Kansas, Minnesota, and Tennessee—calculated rates of MLTSS appeals and grievances as a proportion of beneficiary enrollment, so that they could track patterns or changes in appeals and grievances independent of changes in enrollment, while one state, Delaware, calculated a rate of grievances as a proportion of beneficiary enrollment but did not calculate a rate of appeals. Officials in one of these states told us that calculating rates—rather than by looking only at the numbers of appeals and grievances—allowed more meaningful comparisons of appeals and grievances across MCOs. Officials in this state provided an example of when the state took an action based on appeals rates. The state identified that one MCO had a significantly higher appeals rate than other MCOs, and as a result, put a temporary moratorium on the MCO's implementation of reductions in or terminations of certain services. The state examined the reasons for the high appeals rate—which involved the MCO's process for managing beneficiaries' use of services—and lifted the moratorium after the MCO addressed the issues. After the state lifted the moratorium, the MCO's appeal rate dropped to a rate similar to that of the other two MCOs. The remaining two states, Arizona and Texas, did not calculate rates of appeals and grievances based on beneficiary enrollment.

We analyzed grievance rates in one state and found that one MCO—identified as MCO B in figure 3—consistently had a lower number of grievances than other MCOs in the state. However, when grievances were calculated as a proportion of enrollees, MCO B—which had fewer enrollees than other MCOs—had a higher grievance rate than most other

³¹Kansas officials noted that there were low numbers of appeals and grievances related to nursing facility care, and that in 2017 the state was moving to monitor grievance and appeals of HCBS and nursing facility populations in a more detailed way.

MCOs. See figure 3 for an illustration of the difference in grievance numbers and grievance rates for two of the MCOs in this state.

Figure 3: Comparison of Grievances and Grievance Rates per 10,000 Member Months by Managed Care Organizations in One Selected State



Source: GAO analysis of state data. | GAO-17-632

Using categories of appeals and grievances: The six states varied in the extent to which—and how—they used categories of appeals or grievances to identify beneficiary concerns about specific types of services or access to care issues. States can request that MCOs report beneficiary appeals and grievances in categories based on the type of beneficiary concern. For example, a beneficiary appeal about a reduction in private duty nursing service hours could be categorized as being related to that particular type of service, and a grievance about late transportation services that caused the beneficiary to miss an appointment could be categorized as being related to transportation services. State officials told us that using categories can help them identify patterns or changes in appeals and grievances, and highlight areas where the state could take action to address beneficiary concerns. All states required MCOs to report categories of grievances and four states—Arizona, Kansas, Minnesota, and Texas—required MCOs to report categories of appeals. In the two remaining states, each state was

able to review appeals decisions directly and so did not rely on MCOs to categorize appeals.³²

Examples of Appeals and Grievances Categories

Minnesota had managed care organizations (MCO) categorize appeals and grievances by setting of care, type of service, and the type of issue the beneficiary raised. For example, regarding the types of issues MCOs could report:

- Appeals categories included services and benefits; failure to provide services within contractual timelines; and billing and financial issues, among others.
- Grievance categories included access; coordination of care; and technical competence and appropriateness, among others.

Source: GAO summary of state information. | GAO-17-632.

- Minnesota, for example, asked MCOs to categorize appeals and grievances by setting of care, such as nursing facility, and by type of services, such as companion services or home-delivered meals. The state also asked MCOs to categorize appeals and grievances by the type of issue the beneficiary raised.
- Delaware had MCOs use several categories of grievances, including quality of care, quality of service, and case management. State officials said they regularly review MCOs' grievance data and evaluate the grievance categories, working to refine the categories to make them as useful as possible. For example, they evaluate MCOs' explanations for grievances they categorized as an "other" type of grievance (as opposed to a specific category), in order to identify new types of beneficiary concerns.
- Arizona used several categories of grievances, such as access to care, medical services provision, and transportation. State officials provided an example of how they adjusted categories to reflect emerging areas of concern. They explained that transportation services, which enable MLTSS beneficiaries and other beneficiaries to access care, had the highest number of grievances. As a result, the state required MCOs to work more closely with transportation providers. In addition, the state refined its grievance categories to better track specific types of transportation concerns, such as the timeliness of pick up, unsafe driving, and missed or late appointments.

Monitoring appeals outcomes: The six states varied in the extent to which they monitored whether the appeals that MLTSS beneficiaries filed were ultimately approved or denied by MCOs—that is, whether MCOs reversed their initial decisions to reduce or terminate services or to deny coverage for MLTSS care.³³ Officials from one state said that data on appeals outcomes, particularly decisions where the MCO reversed its

³²Two of the four states that used categories of appeals—Arizona and Texas—were unable to separate MLTSS appeals and grievances from those related to other managed care services or beneficiaries. For the two states that did not use categories of appeals, Tennessee officials told us that the state does not require MCOs to specifically categorize appeals because the state receives information directly on all appeals through its involvement in reviewing and determining outcomes on all appeals, and Delaware officials also told us that the state was involved with determining appeals outcomes.

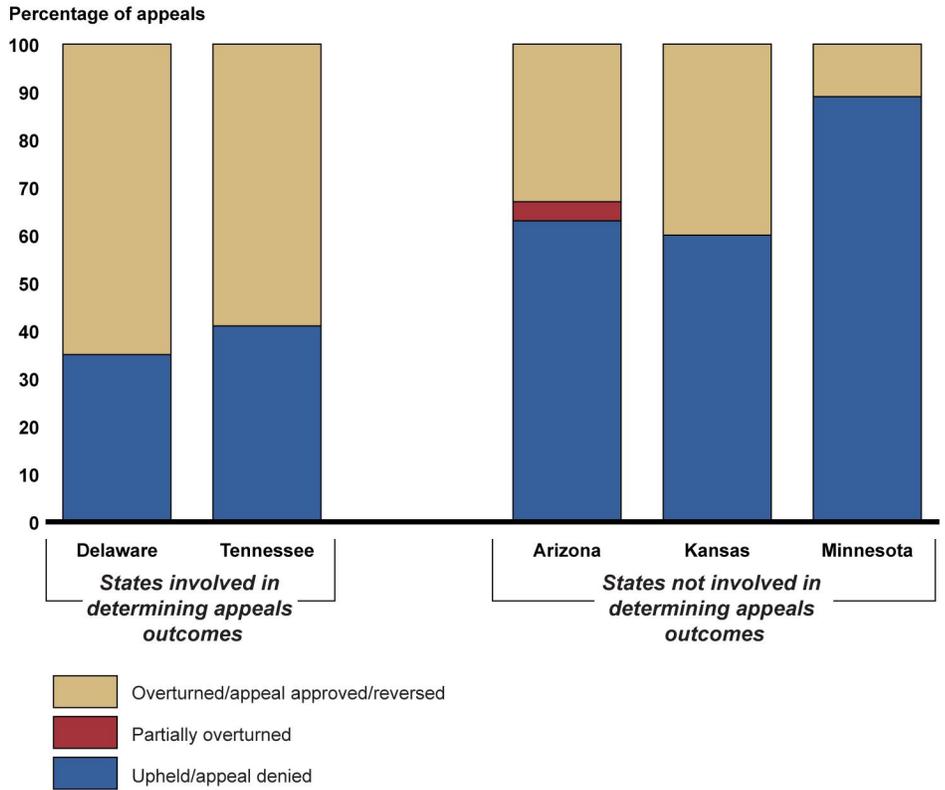
³³Appeals can also be partially overturned, withdrawn, or denied due to exceeding the time frame for appeal.

initial decision, are as important as the data on the appeals themselves. They noted that if MCOs often reverse their decisions, it indicates a problem with beneficiaries being put through appeals unnecessarily. Four states—Delaware, Kansas, Minnesota, and Tennessee—monitored the outcomes of MLTSS appeals. Arizona monitored the outcomes of appeals for its managed care programs generally, though its appeals outcome data did not distinguish all MLTSS-related appeals from other types of appeals. Finally, one state—Texas—had not previously required MCOs to report information about appeals outcomes, but began requiring MCOs to do so during the course of this study, starting in September 2016.

Two of the six states' Medicaid agencies—in Delaware and Tennessee—were actively involved in determining appeals outcomes. In Delaware, nursing staff with the state Medicaid agency reviewed each appeal and represented the state as a voting member on MCO panels for appeals decisions. In Tennessee, the state directly receives and processes all appeals and shares them with the MCO, which then reconsiders its original decision. If the MCO upholds its decision, the state completes its own review and determines whether to uphold or overturn the MCO's decision. Officials from both states said state involvement helped the state identify trends in appeals and address issues, and Delaware officials believed that their involvement was facilitated by the relatively small size of the state. In the remaining four states—Arizona, Kansas, Minnesota, and Texas—appeals outcomes were decided by MCOs without state involvement, though beneficiaries in all states had the right to request a state fair hearing, which could overturn the MCO's decision.

States varied in the extent to which appeals resulted in MCOs' decisions being upheld or reversed. In the two states where the state Medicaid agency was actively involved in the appeals process, a greater share of beneficiary appeals were resolved in favor of the beneficiary—in other words, a greater share of MCOs' initial decisions were overturned—than in the other states. Other factors, such as the type of services being appealed, or the beneficiary populations included in the appeals data, may also affect the rate of appeals approved. (See fig. 4.)

Figure 4: Appeals Outcomes by Proportion of Appeals Upheld, Partially Overturned, or Overturned in Selected States, 2015



Source: GAO summary of state data. | GAO-17-632

Note: This only includes appeals that were resolved, and excludes appeals that were withdrawn, resolved informally, or unresolved. Texas did not receive data on appeals outcomes from MCOs in 2015. Arizona's appeals data are not specific to MLTSS services, but include MLTSS and non-MLTSS services. Kansas's appeals data reflect beneficiaries receiving HCBS care and do not include beneficiaries receiving care in institutions.

Selected States Reported Using Different Types of Compliance Actions to Resolve Issues Affecting MLTSS Beneficiaries

All six states reported taking compliance actions against MCOs in response to issues they identified that affected MLTSS beneficiaries, though to varying degrees.³⁴ States identified issues through their MCO monitoring efforts and other means. States took various actions to resolve those issues, ranging from warning letters or notices to MCOs to financial penalties. For example, in Delaware, the state Medicaid agency issued a formal notice to an MCO about deficiencies the state identified in its quarterly reviews of beneficiaries' medical charts. Delaware found deficiencies with respect to beneficiary contact with behavioral health providers, and difficulty in scheduling timely coordination of care meetings. Arizona assessed financial penalties in response to an MCO's failure to coordinate medically necessary transportation. The state identified the issue through hundreds of beneficiary grievances related to transportation services, which the state tracked to a transportation provider that served MLTSS and other beneficiaries. The prevalence of compliance actions varied across our selected states; some states, for example, reported over 20 instances in which they required MCOs to submit corrective action plans to address issues that affected MLTSS beneficiaries, while other states reported using few corrective action plans from 2013 through 2015.

³⁴We requested that states provide the number of compliance actions—specifically including warning letters or notices to MCOs, corrective action plans, or intermediate sanctions—issued from 2013 through 2015 for issues that affected MLTSS beneficiaries. These issues may not be specific to MLTSS beneficiaries, and may not have always included issues that affected access and quality of care. We did not assess the circumstances under which selected states took compliance actions, and did not assess whether the actions taken were appropriate.

CMS's Oversight Relied Primarily on State Reporting, but Selected States Were Not Always Required to Report Key Information on MLTSS Access and Quality Needed for CMS Oversight

CMS generally depends on quarterly and annual reporting requirements as stipulated in states' special terms and conditions as a framework to monitor access and quality in their MLTSS programs.³⁵ CMS's reporting requirements are customized for each state, and as such, the content and specificity of reports can vary by state. CMS officials told us that as state reports are received, the central and regional office staff reviews them for compliance with federal regulations and the state's particular reporting requirements. Agency officials explained that after reviewing the state reports, regional office staff can contact state Medicaid officials as necessary with questions or concerns. CMS officials indicated that all six of our selected states were compliant with their reporting requirements, and that the agency did not request additional reports from the states from 2013 through 2015. Also, all of our selected states were required to have meetings with CMS at varying intervals, depending on the state. The frequency of these meetings was determined when CMS approved the states' special terms and conditions, and ranged from bimonthly to quarterly.

While CMS has specified certain parameters for state oversight of MLTSS, the agency did not always require the six selected states to report the information needed to monitor this oversight. CMS's 2013 guidance for MLTSS programs highlights the 10 elements that it deems essential for developing and maintaining high-quality programs, which

³⁵This report focuses on the reporting requirements related to the section 1115 and 1915 demonstrations and waivers, the most commonly used authorities for MLTSS programs. In addition to the reporting requirements stipulated in states' special terms and conditions governing demonstration and waiver programs, CMS also depends on the managed care quality measurement and reporting framework that is specified in regulation and applicable to managed care programs across all authorities. The quality provisions in 42 C.F.R. Subpart E provide the general framework across all of managed care for monitoring quality, and are reported separately from the quarterly and annual reporting that is outlined in each state's special terms and conditions for their section 1115 and 1915 demonstrations and waivers.

CMS uses when reviewing or approving state MLTSS programs. In particular, this guidance establishes key elements to ensure access and quality, including qualified providers (which includes an adequate network of qualified providers), participant protections (which includes appeals and grievance processes and reporting of critical incidents), and quality.³⁶ Further, CMS's guidance says that states should provide reports to CMS to demonstrate their oversight of these elements. In addition, federal internal control standards stipulate that agencies conduct monitoring and evaluation activities. In our review of the reporting required of our selected states, however, we found that CMS did not require all states to report on certain areas related to those key elements—namely network adequacy, that is, the sufficiency in the number and types of long-term care providers serving beneficiaries in the managed care plans; critical incidents, which are events or situations that cause or may cause harm to a beneficiary's health or welfare, such as abuse, neglect, or exploitation; and appeals and grievances.³⁷ As a result, we found cases where state reporting did not allow CMS to assess state adherence with federal guidance and oversight of MLTSS access and quality.

Network adequacy. CMS did not require three of our six selected states—Arizona, Minnesota, and Tennessee—to regularly report information on network adequacy, but it did require Delaware, Kansas, and Texas to report such information.³⁸ As part of states' oversight responsibilities of MCOs, CMS requires states to ensure that MCOs maintain a network of providers that is sufficient to provide adequate access to all covered services, and includes network adequacy as 1 of the 10 elements it uses to review, approve and renew MLTSS waivers. CMS regulations direct MCOs to submit assurances of network adequacy to the state. However, CMS

³⁶Centers for Medicare & Medicaid Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (2013). We focused our attention on these elements because, in part, they were directly related to access to and quality of care, and could be reviewed in the context of state reporting requirements.

³⁷Centers for Medicare & Medicaid Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (2013). Appeals and grievance processes and reporting of critical incidents are important to assuring participant protections.

³⁸CMS required all six states to report that they review beneficiary access generally, but did not specifically require all six states to report on network adequacy. CMS officials noted that, under federal regulations, they have the right to request network adequacy information; therefore, CMS may not include it in state reporting requirements.

currently does not require that states report this information to the agency unless it is stipulated in the state's reporting requirements, or if CMS requests it.³⁹ CMS officials said that the agency can request network adequacy information from the states, even though it may not be part of the reporting requirements in the states' special terms and conditions. Given that in recent years CMS has not requested that any of our selected states provide additional information, including network adequacy assurances, the agency may miss potential network adequacy issues in states where there are no specific reporting requirements. Without ongoing monitoring of network adequacy, CMS may not be able identify when enrollment or other trends begin to erode beneficiary access to MLTSS.

Critical incidents reports. CMS required three of our six states—Delaware, Kansas, and Minnesota—to submit analyses or summaries of their MCOs' critical incidents reports, but did not require the other three states—Arizona, Tennessee, and Texas—to do so. Even though Delaware was required to submit information on critical incidents, in our review of two of the state's 2015 quarterly reports, we did not find summaries or data on critical incidents. In addition, Delaware's annual report did not provide any information on critical incidents in the state, but described how the state collects and tracks critical incidents and their outcomes on a monthly basis. This gap in Delaware's reporting, and the lack of a requirement to report in Arizona, Tennessee, and Texas, means that CMS cannot directly monitor the degree to which critical incidents are occurring in these states or how the states are tracking and resolving incidents that involve reports of abuse, neglect, or exploitation of vulnerable beneficiaries.

Appeals and grievances. CMS required all states to report information on complaints or problems reported by consumers, of which appeals and grievances are an important part. However, the level of detail CMS required from each state varied. For example, CMS's reporting requirements for Delaware, Kansas, and Minnesota specifically included a request for MCO appeals and grievance reports with outcomes or overturn rates, which represent the extent that MCOs reverse their decisions to deny certain services, and which can

³⁹Starting in 2018, states will be required to provide assurance to CMS at least annually that the state has reviewed network adequacy data and performed an analysis to validate that the network is sufficient. To foster alignment of state's managed care activities related to network adequacy, CMS has also incorporated the state's adequacy and availability of services standards as a required element of the state's managed care quality strategy.

indicate potential access problems. However, for the other states, Arizona, Texas, and Tennessee, CMS only requires that they report a summary of the types of complaints or grievances that consumers identified about the program in a quarter, including any trends, resolutions of complaints or grievances, and any actions taken or planned to prevent other occurrences. In addition, CMS included language in Texas that required the state to report on appeals, but not necessarily appeals outcomes. A lack of specificity in the reporting requirements may result in CMS not receiving necessary information on beneficiary appeals and grievances. For example, CMS's use of such a broad reporting requirement yielded the following reporting responses from the three states:

- Arizona provided appeals and grievance summaries for two specific programs, but not for the MLTSS population as whole.⁴⁰ CMS officials acknowledged that the grievance and appeals data included in Arizona's quarterly and annual reports were only for those two programs, which aligned with reporting requirements in the state's special terms and conditions. CMS officials told us that they can request additional reports from states at any time, but they had not done so.⁴¹
- Texas did not require its MCOs to report appeals outcomes as of April 2016. However, Texas officials indicated that as of September 2016, they began to require MCOs to report appeals outcomes.
- Tennessee provided appeals data including appeals outcomes in its quarterly report.

As noted earlier, a number of selected states examined MLTSS-related appeals and grievance data—including the rates and categories of appeals and grievances by managed care plans, as well as appeals outcomes—to identify potential areas for greater MCO oversight. Even though the rates of appeals or grievances were available in four of our selected states, CMS did not require any of the

⁴⁰Arizona is required to report appeals and grievances for two programs—Child Rehabilitative Services and Individuals with Serious Mental Illness; individuals in these programs may or may not also receive MLTSS.

⁴¹CMS officials also said that Arizona's EQRO should be reviewing policies and procedures for appeals and grievances, including potentially reviewing a sample of appeals and grievances as part of their recurring annual review. As the state must submit a summary of the EQRO report to CMS, this could be a mechanism through which they obtain appeals and grievance data.

Example of One State’s Reporting Requirements on Events That May Affect Access to Care

Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues; approval and contracting with new plans; benefits; enrollment; grievances; proposed or implemented [level of care] changes; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance and the implementation of managed long-term services and supports, that is relevant to the demonstration; pertinent legislative activity; and other operational issues.

Source: Excerpt from the special terms and conditions associated with one state’s MLTSS authority. | GAO-17-632

states to report them. Furthermore, without requiring states to report readily available information on the rates of appeals and grievances and appeals outcomes, CMS may not be able to identify trends in consumer complaints and denied appeals in a timely manner, and may not be able to identify MCOs that may be inappropriately reducing or denying services.

We also found cases where CMS’s reporting requirements lacked detail, which may have limited the usefulness of the information states provided in certain sections of their reports. Although CMS required all of our selected states to report on “events that may affect access to care” (see sidebar), as well as quality assurance efforts, the requirements were broadly written, and as such, they may not garner the information needed for CMS to monitor access and quality. For example, CMS used the same, or similar, statement to indicate that all states should report on quality assurance efforts: *“Identify any quality assurance and monitoring activities in the quarter.”* In response to this, we found that four states reported general descriptions of their planned and ongoing quality assurance activities for MLTSS or their comprehensive managed care programs as a whole, and often repeated the same or similar information in subsequent quarterly reports.⁴² For example, in Minnesota’s quarterly reports, the state provided little information about its quality assurance efforts other than a description of how the state has a team that meets twice a year to review and analyze performance measure and remediation data. Furthermore, the same information is repeated in multiple quarterly reports.

In discussions with CMS about the differences in reporting requirements stipulated in the special terms and conditions for states’ MLTSS programs in our review, and about the broad language used for certain elements that are key to monitor MLTSS access and quality, agency officials told us that, apart from annual requirements related to quality strategies and

⁴²Also, as part of the required external quality review process in which states assess the quality of care MCOs provided to MLTSS and other beneficiaries in managed care, states contract with an EQRO to produce an annual external quality review technical report. According to CMS, these reports could provide significant insight about changes in the quality of care for MLTSS. CMS may request the EQRO reports from the states if it needs them. CMS officials commented that since 2014 the agency has requested states submit all EQRO technical reports for data abstraction and inclusion in CMS’s annual quality reporting obligations. Starting on July 1, 2018, states will be required to post the EQRO reports on their websites. See Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498 (May 6, 2016).

The Centers for Medicare & Medicaid Services' (CMS) Onsite Review of KanCare.

In response to hundreds of complaints from beneficiaries, providers, and advocates voiced directly to CMS between late 2015 and mid-2016, in October 2016, the agency conducted a detailed, on-site review of KanCare, Kansas's comprehensive managed care program that includes managed long-term services and supports (MLTSS). For this review, CMS requested documentation from the state beyond what the state is required to report—such as managed care organization (MCO) oversight policies and procedures. The agency also reviewed information on specific complaints, and met with state officials in multiple state agencies to discuss overarching concerns and to remediate individual complaints.

As a result of this review, CMS found systemic, longstanding program deficiencies in Kansas's state oversight that it had not previously identified from the information obtained through the state's required reporting. Specifically, CMS found that the Kansas state agency was substantively out of compliance with federal statutes and regulations as well as with its approved state plan, and that this noncompliance "placed the health, welfare, and safety of KanCare beneficiaries at risk and required immediate action." CMS also found that Kansas's state agency's oversight of its MCOs had diminished since the beginning of its operation, that it did not seem to be analyzing access to care reports, and that it did not have a comprehensive system for reporting and tracking critical incidents, among other issues.

As of July 2017, Kansas was implementing a corrective action plan to address these issues.

Source: January 13, 2017 letter from CMS to Kansas Department of Health and Environment, and GAO interview with CMS officials. | GAO-17-632

external quality review, CMS does not have one consistent approach for monitoring MLTSS programs. Instead, CMS customizes its monitoring of MLTSS to each state's program to accommodate the variability among MLTSS programs.⁴³ The customized approach to monitoring is reflected in the quarterly and annual reporting requirements in the program's special terms and conditions. When asked about differences in content and specificity in reporting requirements for the same elements across states, agency officials said that these differences could be partly due to changes in the staff who write the reporting requirements. They also said that terminology of requirements may evolve as state programs age with later versions, reflecting more refined language. Also, states with more recently approved programs may have requirements that reflect lessons CMS staff has learned about the programs. However, any gaps in reporting requirements, and gaps in state reporting from what CMS has required, may mean that CMS does not always have the data to monitor key aspects of MLTSS access and quality among selected states and may be unable to reliably detect state or MCO practices that do not meet CMS's guidance. See sidebar for an example of how oversight of access and quality is diminished when CMS does not obtain necessary information.

The new 2016 managed care final rule will require states to report annually on their managed care programs, beginning one year following the release of new CMS guidance. The managed care rule specifies that annual reports must include, among other things: appeals, grievances, and state fair hearings; access and availability of services; MCO performance on quality measures; and results of any corrective action plans, sanctions, or other actions taken by the states.⁴⁴ At the time of our review, the specific requirements were not yet known, including whether states would need to address MLTSS programs separately from managed care programs for acute care services, which have different

⁴³As discussed previously, CMS has consistent annual reporting requirements for quality strategies and external quality review as specified in regulation for all managed care programs, including those not specifically for MLTSS. CMS regulations and guidance include reporting requirements for MCO performance on quality measures for states' quality strategies and EQROs. For example, CMS has provided guidance on a quality strategy checklist for states, which will remain in effect until the quality strategy provisions of the 2016 managed care rule become effective.

⁴⁴States will also be required to post the annual reports publicly on their websites.

networks of providers. As of July 2017, HHS had not yet issued guidance clarifying the format of the annual reports.⁴⁵

Conclusions

Using managed care to deliver long-term services and supports offers states an opportunity to allow Medicaid beneficiaries with significant health needs to live and receive care in the setting of their choice, expand access to home and community-based care, and provide such care at a potentially lower cost than institutional care. Although states' increasing use of MLTSS can yield benefits for improved access to quality care, it also heightens the importance of federal and state oversight, which is critical to ensure that the potentially vulnerable populations served by these programs—such as the elderly and adults with physical or developmental disabilities—are able to obtain the care they need, when they need it. States rely on MCOs to coordinate MLTSS care, but remain responsible for monitoring beneficiaries' access to and quality of care. Along with the states, CMS plays an important role in establishing requirements for MLTSS programs and overseeing states' programs. To monitor MLTSS programs, CMS relies in large part on states' reports on different aspects of their programs. CMS's reporting requirements are critical to CMS's oversight because they establish the foundation for the information CMS will receive about MLTSS programs and the beneficiaries they serve. However, on the basis of our review, CMS's requirements for state reporting do not always include key elements necessary for the agency to monitor certain key aspects of MLTSS beneficiaries' access and quality of care, including data related to appeals and grievances, network adequacy, and critical incident tracking. As a result, these requirements do not ensure CMS has information for all of the key areas identified in its 2013 guidance for MLTSS. Without state reporting requirements that provide CMS with necessary information on MLTSS programs, CMS's ability to monitor programs, identify potential problems, and take action as needed, may be limited.

⁴⁵In December 2016, in commenting on a draft of our report examining MLTSS rate-setting, HHS said that it intended to release guidance clarifying the format of the annual reports. See [GAO-17-145](#).

Recommendation

To improve CMS's oversight of states' MLTSS programs, we recommend that the Administrator of CMS take steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its comments, which are reprinted in appendix II, HHS concurred with our recommendation and described certain of its efforts to address it. HHS also stated that it is in the process of reviewing its May 2016 Medicaid managed care regulations in order to prioritize beneficiary outcomes and state priorities, and will take our recommendation into consideration as part of that review. HHS stated that it takes seriously its effort to oversee access and quality in MLTSS programs and that it shares responsibility with states to protect beneficiaries. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, the Administrator of the Administration for Community Living, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or at iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff that made key contributions to this report are listed in appendix III.



Letter

Katherine M. Iritani
Director, Health Care

Appendix I: Characteristics of States' MLTSS Programs Selected for Our Review

Our six selected states—Arizona, Delaware, Kansas, Minnesota, Tennessee, and Texas—have managed long-term services and supports (MLTSS) programs that varied across a number of characteristics, such as program start year, cost, and enrollment. For example, the MLTSS programs in Delaware and Kansas both began within the last five years, while the MLTSS program in Arizona began over 25 years ago. In addition, in 2015, total capitated payments to managed care organizations (MCO) for MLTSS, as reported by the six states, ranged from \$438.9 million in Delaware to \$3.6 billion in Texas. Also, the number of MLTSS beneficiaries reported by the states ranged from 6,340 beneficiaries in Delaware to almost 98,000 beneficiaries in Texas. (See table 2.) The number of beneficiaries in some programs has changed in recent years. For example, between 2013 and 2015, Texas increased the number of MLTSS beneficiaries by over 145 percent, after the state expanded its community-based MLTSS program to rural areas in 2014 and began including beneficiaries receiving nursing facility care in the program in 2015.

Appendix I: Characteristics of States' MLTSS Programs Selected for Our Review

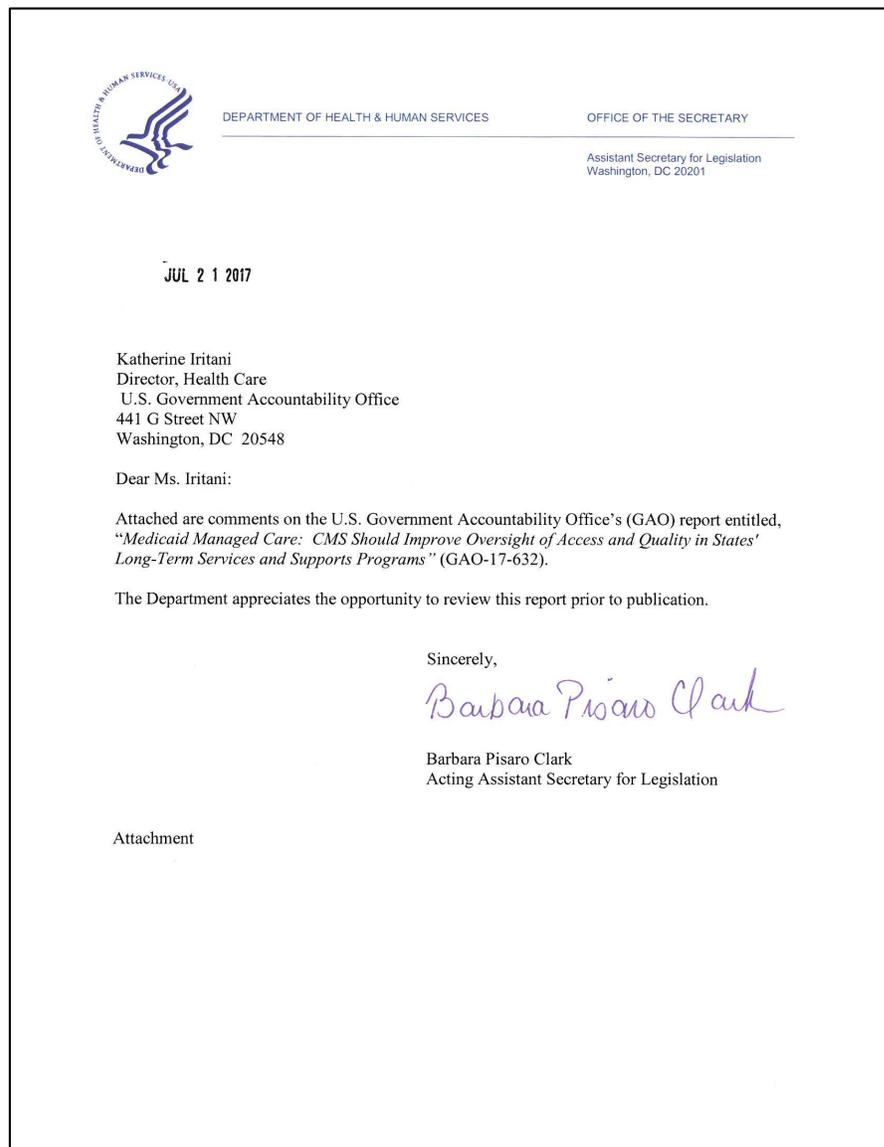
Table 2: Characteristics of Managed Long-Term Services and Supports (MLTSS) Programs in Selected States, 2015

State	Program start year	Current program authority	Total capitated payments to managed care organizations (MCO) for beneficiaries receiving MLTSS (dollars in millions)	Number of beneficiaries receiving MLTSS	Number of MCOs under contract	Contract period
Arizona	1989	Section 1115 demonstration	1,570.3	55,475	Three MCOs One state agency	5 years 1 year with state agency
Delaware	2012	Section 1115 demonstration	438.9	6,340	Two MCOs	3 years, plus 2 option years
Kansas	2013	Section 1115 demonstration with section 1915(c) waivers	1,272.6	33,255	Three MCOs	3 years, plus 2 option years
Minnesota	1997 and 2005 (two programs)	Section 1915(a)/(c) and section 1915(b)/(c) waivers	636.0	33,185	Seven MCOs	1 year
Tennessee	2010	Section 1115 demonstration	1,488.1	30,166	Three MCOs	3 years, plus 5 option years
Texas	1998	Section 1115 demonstration	3,591.0	97,914	Five MCOs	3 years, plus 5 option years

Source: GAO analysis of state-reported data, and Centers for Medicare & Medicaid Services data. | GAO-17-632

Note: Data on payments are for calendar year 2015 for all states except for Arizona, which uses the federal fiscal year for one program and the state fiscal year for its other program. Data on beneficiaries for Arizona, Delaware, Kansas, and Tennessee are as of December 2015. Data on beneficiaries for Minnesota represent full-year equivalents based on member months for calendar year 2015. Data on beneficiaries for Texas represent average monthly enrollment for calendar year 2015.

Appendix II: Comments from the Department of Health and Human Services



GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: CMS SHOULD IMPROVE OVERSIGHT OF ACCESS AND QUALITY IN STATEES' LONG-TERM SERVICES AND SUPPORTS PROGRAMS (GAO-17-632)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on Medicaid managed long-term services and supports (MLTSS) programs. HHS takes seriously its effort to oversee access and quality in states' MLTSS programs.

MLTSS offers states a broad and flexible set of program design options, and may be used as a mechanism for expanding home and community-based services, promoting community inclusion, ensuring quality, and increasing efficiency. States can implement MLTSS using an array of managed care authorities, including a 1915(a) voluntary program, a 1932(a) state plan amendment, a 1915(b) waiver, or a section 1115 demonstration. States are increasingly incorporating populations and services that have long been excluded from capitated managed care arrangements into these models of care. Providing more integrated care for populations such as those who are dually eligible for Medicare and Medicaid, and coordinating acute care with long term services and supports hold the promise of delivering better care at lower costs.

Recognizing this shift in delivery system design and wanting to maximize the positive experience of beneficiaries as they make the transition to more integrated service models, HHS has provided guidance to states on the implementation of their MLTSS programs. This includes guidance issued by HHS in May 2013 that provided ten key principles inherent in a strong MLTSS program, including a focus on person-centered processes to ensure active participation by the beneficiary, or his/her designee, in the service planning and delivery process. HHS believes these guiding principles, while not exhaustive and subject to further refinement as states and HHS gain further experience, are critical to the successful implementation and operation of MLTSS programs that support greater integration of care for beneficiaries with the most significant needs.

In May 2016, HHS finalized a rule for Medicaid managed care (81 FR 27497). The rule integrates the elements found in the 2013 MLTSS guidance and includes areas such as qualifications and credentialing of providers, accessibility of providers to meet the needs of MLTSS beneficiaries, and also requires managed care plans to participate in efforts by the state to prevent, detect, and report critical incidents. HHS is in the process of conducting a review of these and other regulations in order to prioritize beneficiary outcomes and state priorities. HHS will continue to work with the stakeholder community to develop comprehensive and meaningful systems of care that allow state and local leadership flexibility to better position Medicaid programs in meeting the needs of their beneficiaries. HHS and states share a joint responsibility to protect beneficiaries and the integrity of the program and HHS will hold true to this tenet as we review the current regulations to make sure the focus is on beneficiary outcomes.

GAO's recommendation and HHS's response are below.

GAO Recommendation

To improve CMS's oversight of states' MLTSS programs, we recommend that the Administrator of CMS take steps to identify and obtain key information needed to oversee states' efforts to

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: CMS SHOULD IMPROVE OVERSIGHT OF ACCESS AND QUALITY IN STATEES' LONG-TERM SERVICES AND SUPPORTS PROGRAMS (GAO-17-632)

monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.

HHS Response

HHS concurs with this recommendation. HHS is in the process of conducting a review of the Medicaid managed care regulations that were finalized in May 2016 in order to prioritize beneficiary outcomes and state priorities and will take this recommendation into consideration as we review the rule. HHS will continue to assist states through technical guidance and other means to ensure MLTSS programs meet the needs of their beneficiaries. HHS is also in the process of enhancing capacity to measure, monitor and improve care and quality across a number of domains, including MLTSS.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Susan Barnidge and Leslie V. Gordon (Assistant Directors), Shamonda Braithwaite, Robin Burke, Caroline Hale, Corissa Kiyon-Fukumoto, and Laurie Pachter made key contributions to this report. Also contributing were Vikki Porter and Emily Wilson.

Appendix IV: Accessible Data

Data Tables

Accessible Data for Figure 1: States with Current or Planned Managed Long-Term Services and Supports (MLTSS) Programs, May 2017
Has MLTSS program (22 states)

Arizona

California

Delaware

Florida

Hawaii

Illinois

Iowa

Kansas

Massachusetts

Michigan

Minnesota

New Jersey

New Mexico

New York

North Carolina

Ohio

Rhode Island

South Carolina

Tennessee

Texas

Virginia

Wisconsin

Has plans to implement MLTSS program (5 states)

Kentucky

Nebraska

New Hampshire

Oklahoma

Pennsylvania

Does not have MLTSS program (24 states)

Alabama

Alaska

Arkansas

Colorado

Connecticut

Georgia

Idaho

Indiana

Louisiana

Maine

Maryland

Mississippi

Missouri

Montana

Nevada

North Dakota

Oregon

South Dakota

Utah

Vermont

Washington

West Virginia

Wyoming

Accessible Data for Figure 2: Managed Care Organizations' (MCO) Role in Coordinating Services for Beneficiaries in Managed Long-Term Services and Supports (MLTSS) Programs

1. Generally, state determines eligibility of and works to enroll beneficiary in MCO.
The state, or an independent entity, determines eligibility and works with the beneficiary to enroll in an MCO. To be eligible for MLTSS, a beneficiary must meet state-established criteria on the level of care needed, such as needing an institutional level of care.
2. MCO assesses beneficiary's needs.
The MCO assesses the beneficiary's physical, functional, and psychosocial needs such as health status, treatment needs, and preferences for care. These also include social, employment, and transportation needs and preferences.

3. MCO develops service plan with beneficiary, including care in community or institution.
 The MCO is responsible for developing/revising a service plan through a process that actively engages the beneficiary and individuals of choice. The service plan must address how a combination of covered services and available community supports will meet the beneficiary's or caregiver's needs and preferences, including preferences for receiving care in the community or in an institution.

4. MCO coordinates provision of services to beneficiary.
 The MCO coordinates the provision of all services to the beneficiary. Services may include MLTSS—both community-based and institutional services—as well as physical and behavioral health services.

5. MCO periodically reassesses beneficiary's needs.
 The MCO reassesses the beneficiary's needs at least every 12 months, after a significant change in the beneficiary's needs or circumstances, or at the request of the beneficiary.

Accessible Data for Figure 3: Comparison of Grievances and Grievance Rates per 10,000 Member Months by Managed Care Organizations in One Selected State

MCO A	Total number of grievances	MCO B	Total number of grievances
2013 Q2	192	2013 Q2	103
2013 Q3	197	2013 Q3	200
2013 Q4	225	2013 Q4	125
2014 Q1	194	2014 Q1	85
2014 Q2	174	2014 Q2	86
2014 Q3	270	2014 Q3	98
2014 Q4	263	2014 Q4	85
2015 Q1	326	2015 Q1	136
2015 Q2	272	2015 Q2	144
2015 Q3	276	2015 Q3	171
2015 Q4	324	2015 Q4	215
2016 Q1	209	2016 Q1	156

MCO A	Rate of grievances	MCO B	Rate of grievances
2013 Q2	5.42	2013 Q2	14.94

MCO A	Rate of grievances	MCO B	Rate of grievances
2013 Q3	5.52	2013 Q3	28.42
2013 Q4	6.3	2013 Q4	17.34
2014 Q1	5.41	2014 Q1	11.55
2014 Q2	4.88	2014 Q2	11.58
2014 Q3	7.6	2014 Q3	13.05
2014 Q4	7.37	2014 Q4	11.25
2015 Q1	7.85	2015 Q1	9.81
2015 Q2	6.52	2015 Q2	10.28
2015 Q3	6.26	2015 Q3	10.96
2015 Q4	7.81	2015 Q4	14.07
2016 Q1	5.15	2016 Q1	10.27

Accessible Data for Figure 4: Appeals Outcomes by Proportion of Appeals Upheld, Partially Overturned, or Overturned in Selected States, 2015
States involved in determining appeals outcomes

	Upheld	Partially	Overturned
Delaware	35	0	65
Tennessee	41	0	59

States not involved in determining appeals outcomes

	Upheld	Partially	Overturned
Arizona	63	4	33
Kansas	60	0	40
Minnesota	89	0	11

Agency Comment Letter

Accessible Text for Appendix II: Comments from the Department of Health and Human Services

Page 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

JUL 21 2017

Katherine Iritani Director, Health Care

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs" (GAO-17-632).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Barbara Pisaro Clark

Acting Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: CMS SHOULD IMPROVE OVERSIGHT OF ACCESS AND QUALITY IN STATEES' LONG-TERM SERVICES AND SUPPORTS PROGRAMS (GAO-17-632)

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Page 3

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HHS Response

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