



November 2020

MEDICAID LONG- TERM SERVICES AND SUPPORTS

Access and Quality Problems in Managed Care Demand Improved Oversight

Accessible Version

GAO Highlights

Highlights of [GAO-21-49](#), a report to the Chairman, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

An increasing number of states are using managed care to deliver long-term services and supports in their Medicaid programs, thus delegating decisions around the amounts and types of care beneficiaries receive to MCOs. Federal guidance requires that MLTSS programs include monitoring procedures to ensure the appropriateness of those decisions for this complex population, which includes adults and children who may have physical, cognitive, and mental disabilities.

GAO was asked to review care management in MLTSS programs. Among other things, this report examines state monitoring of care management, and CMS oversight of state implementation of 2016 requirements related to MLTSS quality and access. GAO examined documentation of monitoring procedures and problems identified in six states selected for variation in program age and location. GAO reviewed federal regulations and oversight documents, interviewed state and federal Medicaid officials, and assessed CMS's policies and procedures against federal internal control standards.

What GAO Recommends

GAO is making two recommendations to CMS to (1) develop a national strategy for overseeing MLTSS, and (2) assess the nature and prevalence of MLTSS quality and access problems across states. CMS did not concur with the recommendations. GAO maintains the recommendations are warranted, as discussed in this report.

View [GAO-21-49](#). For more information, contact Carolyn L. Yocom, (202) 512-7114, yocomc@gao.gov.

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What GAO Found

At the state and federal levels, GAO found weaknesses in the oversight of Medicaid managed long-term services and supports (MLTSS), which assist individuals with basic needs like bathing or eating.

Through various monitoring approaches, six selected states identified significant problems in their MLTSS programs with managed care organization (MCO) performance of care management, which includes assessing beneficiary needs, authorizing services, and monitoring service provision to ensure quality and access to care. State efforts may not be identifying all care management problems due to limitations in the information they use to monitor MCOs, allowing some performance problems to continue over multiple years.

Performance Problems in Managed Care Organization (MCO) Care Management, Identified by Selected States

Problem Area	Example
Service Authorizations	Five of the six selected states found one or more MCOs had problems with authorizing services or notifying beneficiaries of changes to their services. Between 2018 and 2019, Virginia found that three of six MCOs had inappropriately reduced services for 33 to 53 percent of beneficiary cases reviewed.
Service Coordination and Monitoring	Five of the six selected states had one or more MCOs that did not adequately coordinate or monitor beneficiaries' quality of care. Between 2015 and 2020, Arizona found that the MCO responsible for beneficiaries with developmental disabilities had repeated access and quality of care problems such as medication errors and lack of investigating quality incident reports.

GAO found that the Centers for Medicare & Medicaid Services' (CMS) oversight of state implementation of its 2016 requirements, and of access and quality in MLTSS more broadly, was limited. This hinders the agency's ability to hold states and MCOs accountable for quality and access problems beneficiaries may face.

- **Oversight did not detect quality and access problems.** GAO identified cases where CMS learned about problems not through its regular oversight, but instead from beneficiary complaints, media reports, or GAO. CMS officials said that states had not reported these problems to the agency.
- **Lack of national oversight strategy and assessment of problems in MLTSS.** Weaknesses in oversight reflect a broader area of concern—namely, that CMS lacks a strategy for oversight. CMS also has not assessed the nature and extent of access and quality problems across states. Without a strategy and more robust information, CMS risks being unable to identify and help address problems facing beneficiaries. As of July 2020, CMS had convened a new workgroup focused on MLTSS oversight, though the goals and time frames for its work were unclear.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FTE	full-time equivalent
HHS	Department of Health and Human Services
LTSS	long-term services and supports
MCO	managed care organization
MLTSS	managed long-term services and supports

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November 16, 2020

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

In the coming decades, the need for long-term services and supports (LTSS) is expected to increase, in part, due to the aging of the population. Medicaid, a federal-state program that finances health care for low-income and medically needy individuals, is the nation’s primary payer of LTSS. Medicaid spending for LTSS is significant, almost one third of total program spending annually.¹ LTSS include a broad array of health care, personal care, and supportive services that assist adults and children who have different types of physical, cognitive, or mental disabilities or conditions. LTSS can be provided in institutional settings—such as nursing facilities—or in the home and other community-based settings. These services can include assistance with eating, bathing, or managing medications. While Medicaid beneficiaries who meet the requirements to receive LTSS may have functional needs significant enough to qualify for care in a nursing facility, the majority of Medicaid spending on LTSS is for care beneficiaries receive in a home or community-based setting, which are often the preferred settings for care.²

An increasing number of states have chosen to provide LTSS through a managed care delivery model, referred to as managed long-term services and supports (MLTSS). The number of states with MLTSS programs grew from eight in 2004 to 26 in 2020. Under managed care, states contract with managed care organizations (MCO) to provide a specific set of covered services in return for a fixed periodic payment per beneficiary—

¹In fiscal year 2016, the most recent year for which data are available, LTSS accounted for about \$167 billion of \$549 billion in total federal and state Medicaid spending. See IBM Watson Health, *Medicaid Expenditures for Long-Term Services and Supports in FY 2016* (May 2018).

²Services provided in home and community-based settings accounted for 57 percent of total Medicaid LTSS spending in fiscal year 2016, the most recent year for which data are available. IBM Watson Health, 2018.

typically, per member per month.³ For MLTSS, states also delegate the responsibility for care management to MCOs. For the purposes of this report, we define care management for MLTSS as including a range of responsibilities, including health assessments, care planning, service authorization, and service coordination and monitoring. Effective care management is critical to ensuring beneficiaries are accessing quality services in the types and amounts of care needed. Ineffective care management can result in, for example, increased falls and injuries that require higher levels of care at higher cost and undetected cases of abuse and neglect.

States and the federal government share in the responsibility for oversight of MLTSS, including the effectiveness of MCO care management in ensuring quality care and beneficiaries' access to care. In 2013, the Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, issued guidance on the key elements states should have in place when transitioning to MLTSS, emphasizing the need for states to actively monitor MCO care management.⁴ In 2016, CMS issued new rules for Medicaid managed care, including requirements for state contracts with MCOs, requirements for states to implement beneficiary supports and protections for LTSS beneficiaries, and requirements related to states' monitoring of MCOs, among other things.⁵ Under these rules states are required to report the results of their monitoring efforts to CMS, and both states and CMS are authorized to impose sanctions when MCOs do not comply with requirements.

Our past work has identified a number of weaknesses in state and federal oversight of Medicaid LTSS and MLTSS specifically, putting beneficiary

³States may have different types of managed care arrangements for LTSS, including contracting with MCOs and with prepaid inpatient health plans, though the latter is done less frequently. In this report, we are referring to risk-based managed care that provides LTSS to beneficiaries through comprehensive MCOs that cover LTSS as well as acute services or through MCOs that cover MLTSS only.

⁴CMS is the agency within the Department of Health and Human Services (HHS) responsible for overseeing the Medicaid program. See Centers for Medicare & Medicaid Services, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs* (2013).

⁵Medicaid 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. 27,498, (May 6, 2016). In November 2020, CMS issued a final rule revising some portions of the 2016 final rule; those changes were outside the scope of our report.

health and safety, as well as federal dollars at risk.⁶ In light of these past findings and the increasing use of MLTSS, you asked us to further examine state and federal oversight of MLTSS. In this report we examine

1. MCO care management for selected beneficiaries;
2. selected states' monitoring of MCO care management for beneficiaries; and
3. CMS's oversight of the effectiveness of state implementation of recent regulatory requirements related to ensuring quality and access in MLTSS.

To examine MCO care management for selected beneficiaries, we reviewed MCO records for 37 Medicaid beneficiaries receiving LTSS. The beneficiaries were all enrolled in the same MCO in one state.⁷ We selected beneficiaries with varied experiences in the MCO's authorization of personal care services, a service for which the MCO has discretion in determining the number of service hours a beneficiary is authorized to receive.⁸ Specifically, we randomly selected eight beneficiaries in each of the following four groups (32 beneficiaries in total): those with an increase, a decrease, both an increase and decrease, or no change in the number of hours of personal care authorized by the MCO in 2019.⁹ Within each of these groups, we selected beneficiaries to achieve variation in hospital use. We randomly selected six beneficiaries with one or more hospitalizations and two beneficiaries with no hospitalizations in 2019 within each group. In addition to these 32 beneficiaries, we selected a judgmental sample of five beneficiaries with at least one of the following characteristics: they filed an appeal related to the MCO's determination of the amount of services to approve, they had a pressure ulcer, they had a

⁶See GAO, *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs*, [GAO-17-632](#) (Washington, D.C.: Aug. 14, 2017); *Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports*, [GAO-17-145](#) (Washington, D.C.: Jan. 9, 2017); and *Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services*, [GAO-18-103](#) (Washington, D.C.: Dec. 14, 2017).

⁷We selected this MCO because it had the largest enrollment in the state. We selected beneficiaries who were enrolled with the MCO for at least 6 months in 2019.

⁸Personal care services assist beneficiaries with activities of daily living, such as bathing, dressing, and toileting.

⁹The MCO provided individual level data, which was used to identify the beneficiaries who fell within these groups.

high number of emergency department visits, or they had multiple changes in authorized services.¹⁰

For the 37 selected beneficiaries, we reviewed the MCO records of health assessments prepared by the care coordinators; care plans developed with the beneficiary; authorizations for personal care services, which included notes detailing any denials of care; and the outcomes of any beneficiary appeals related to denied care. We also reviewed any notes of beneficiary care coordinators, who are responsible for conducting assessments, developing care plans, and coordinating and monitoring care. The time period of the records for selected beneficiaries varied and depended, in part, on how long the person had been enrolled. To supplement our review, we reviewed the MCO's policies, procedures, and training materials related to care management. We interviewed officials with the MCO about how care management is documented, and previewed the data systems used to coordinate and monitor care. The findings from our review are not generalizable to this MCO's entire beneficiary population or to other MCOs in the same or in different states. Additionally, we reviewed related findings of state Medicaid agency reviews and federal reviews of MCO records for beneficiaries receiving LTSS.

To examine selected states' monitoring of MCO care management for beneficiaries, we reviewed documentation of state MLTSS monitoring efforts from six states for state fiscal years 2017 through January 2020. Out of the 26 states with MLTSS programs in 2020, we selected a nongeneralizable sample of six states—Arizona, Florida, Iowa, New York, Texas, and Virginia. The selected states reflected variation in MLTSS program age, size, and geographic region. (See app. I.) Together, these states served 50 percent of Medicaid beneficiaries in MLTSS programs in 2018, the most recent year of available data.¹¹ We collected information on the approaches the selected states' Medicaid agencies used to monitor MCO care management, examined state documentation of the findings from these different monitoring approaches, and interviewed

¹⁰Pressure ulcers are outcomes that may occur because of lack of effective care management.

¹¹This reflects CMS's estimate of the number of MLTSS users or enrollees, some of which may not have received LTSS. See Centers for Medicare & Medicaid Services and Mathematica Policy Research, *Medicaid Managed Care Enrollment and Program Characteristics, 2018* (2020).

state Medicaid officials about the approaches and findings.¹² The documents reviewed included the results of state reviews of MCOs, beneficiary case file reviews, state analysis of appeals and grievance data, and external quality reviews commissioned by the state. When available, we reviewed relevant state Inspector General findings. We also reviewed documentation related to MLTSS care management litigation in our selected states from 2014 to 2018. To supplement this work, we interviewed stakeholders from seven protection and advocacy organizations in these states, and officials from five MCOs selected to reflect variation in size and whether they were part of a national organization.¹³

To examine CMS's oversight of the effectiveness of state implementation of recent regulatory requirements related to ensuring quality and access in MLTSS, we reviewed relevant CMS documents and interviewed agency officials. In particular, we reviewed CMS guidance and other documentation related to requirements included in the May 2016 Medicaid managed care final rule, such as the beneficiary protections, monitoring activities, and contract provisions that states were required to implement. We also reviewed CMS's assessment of 24 MLTSS states' compliance with contract requirements related to care management, appeals and grievances, and other topics. We also reviewed draft work plans describing planned changes in CMS oversight of MLTSS and Medicaid managed care more broadly. We asked CMS officials about their approach to overseeing MLTSS programs, their awareness of any quality and access problems in the states' MLTSS programs, and the extent to which they worked to resolve those problems; we also interviewed officials from our selected states about their implementation of regulatory requirements.¹⁴ To assess CMS's oversight efforts, we used federal regulations related to monitoring and reporting on Medicaid managed care and to protections for MLTSS beneficiaries. We also considered the extent to which CMS's oversight efforts are consistent with

¹²Using a standardized data collection instrument, we asked state officials to confirm whether the state used certain monitoring approaches, including, for example, reviews of MCOs' operations, beneficiary case file reviews, and analysis of appeals data from MCOs.

¹³The protection and advocacy organizations were selected based on information from the Administration for Community Living. The MCOs participated in MLTSS programs in three of the selected states.

¹⁴We also interviewed officials with HHS's Administration for Community Living, which is responsible for increasing individuals' access to community supports.

relevant federal internal control standards, specifically those related to monitoring, risk assessment, and information.¹⁵

We conducted this performance audit from September 2019 to November 2020 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.

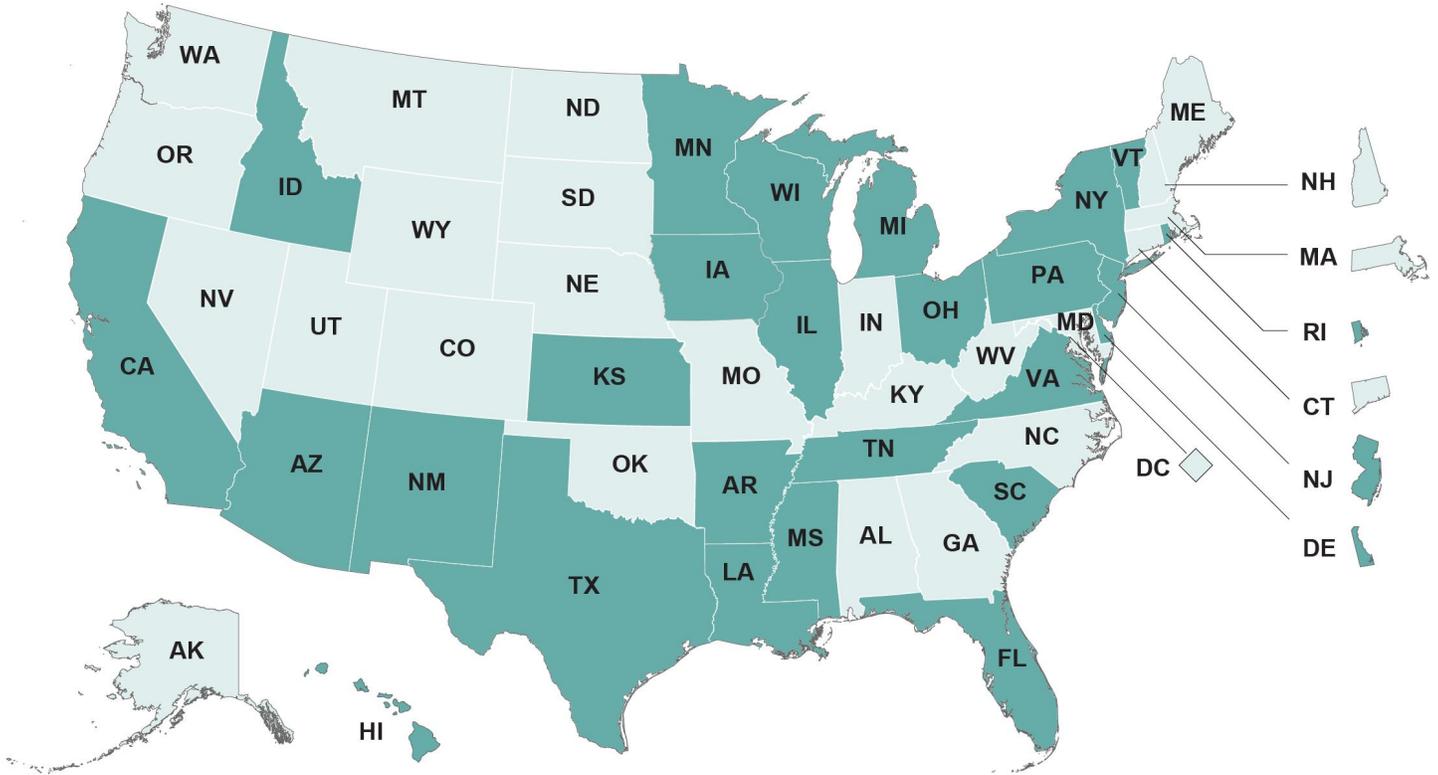
Background

Twenty-six states operated Medicaid MLTSS programs as of July 2020. (See fig. 1.) Collectively, these state programs serve over a million beneficiaries.¹⁶ State 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 and which services to cover in the program.

¹⁵Internal 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. We determined that the monitoring, risk assessment, and information and communication components of internal control were significant to this objective, along with the underlying principles that management should establish and operate monitoring activities; identify, analyze, and respond to risks related to objectives; and use quality information to achieve objectives. GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

¹⁶This reflects CMS's estimate of the number of MLTSS users as of July 2018, and does not include beneficiaries who were enrolled in an 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, 2018* (2020).

Figure 1: States with Managed Long-Term Services and Supports (MLTSS) Programs, as of July 2020



States with MLTSS programs (26 states)
 States without MLTSS programs (25 states)

Source: GAO summary of Centers for Medicare & Medicaid Services information. | GAO-21-49

Data table for Figure 1: States with Managed Long-Term Services and Supports (MLTSS) Programs, as of July 2020

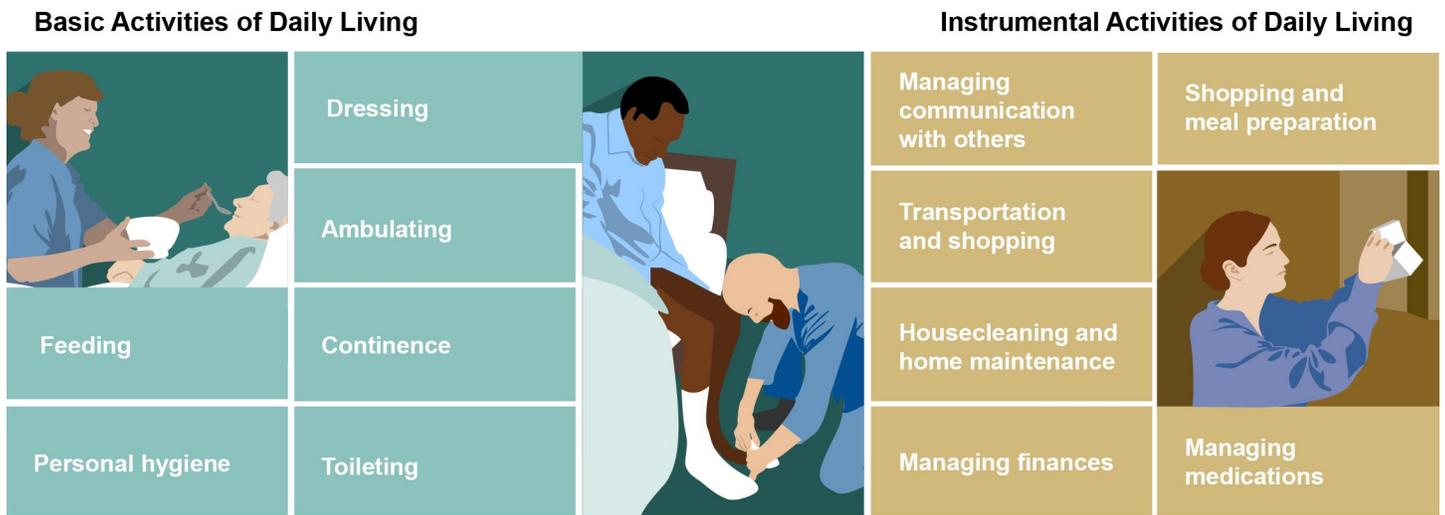
States with MLTSS programs	States without MLTSS programs
1. Arizona	1. Alabama
2. Arkansas	2. Alaska
3. California	3. Colorado
4. Delaware	4. Connecticut
5. Florida	5. District of Columbia
6. Hawaii	6. Georgia
7. Idaho	7. New Hampshire
8. Illinois	8. Indiana
9. Iowa	9. Kentucky
10. Kansas	10. Maine
11. Louisiana	11. Maryland
12. Massachusetts	12. Massachusetts
13. Michigan	13. Missouri
14. Minnesota	14. Montana
15. New Jersey	15. Nebraska

States with MLTSS programs	States without MLTSS programs
16. New Mexico	16. Nevada
17. New York	17. North Carolina
18. Ohio	18. North Dakota
19. Pennsylvania	19. Oklahoma
20. Rhode Island	20. Oregon
21. South Carolina	21. South Dakota
22. Tennessee	22. Utah
23. Texas	23. Washington
24. Vermont	24. Wyoming
25. Virginia	25. West Virginia
26. Wisconsin	

MLTSS Beneficiaries and Services

Medicaid beneficiaries must meet income and asset requirements, as well as state-established criteria on the level of care necessary to qualify for MLTSS. In general, MLTSS beneficiaries may require assistance to care for themselves, because of physical, cognitive, or mental disabilities or conditions. (See fig. 2.) To address these functional needs, LTSS include a broad range of health and health-related services and non-medical supports, such as personal care services, medical equipment, adult day care, home delivered meals, and non-emergency transportation.

Figure 2: Needs of Medicaid Beneficiaries That May Be Addressed with Long-Term Supports and Services



Source: GAO analysis of National Library of Medicine information. | GAO-21-49

Data for Figure 2: Needs of Medicaid Beneficiaries That May Be Addressed with Long-Term Supports and Services

Basic Activities of Daily Living

- Dressing
- Ambulating
- Contenance
- Toileting
- Feeding
- Personal hygiene

Instrumental activities of daily living

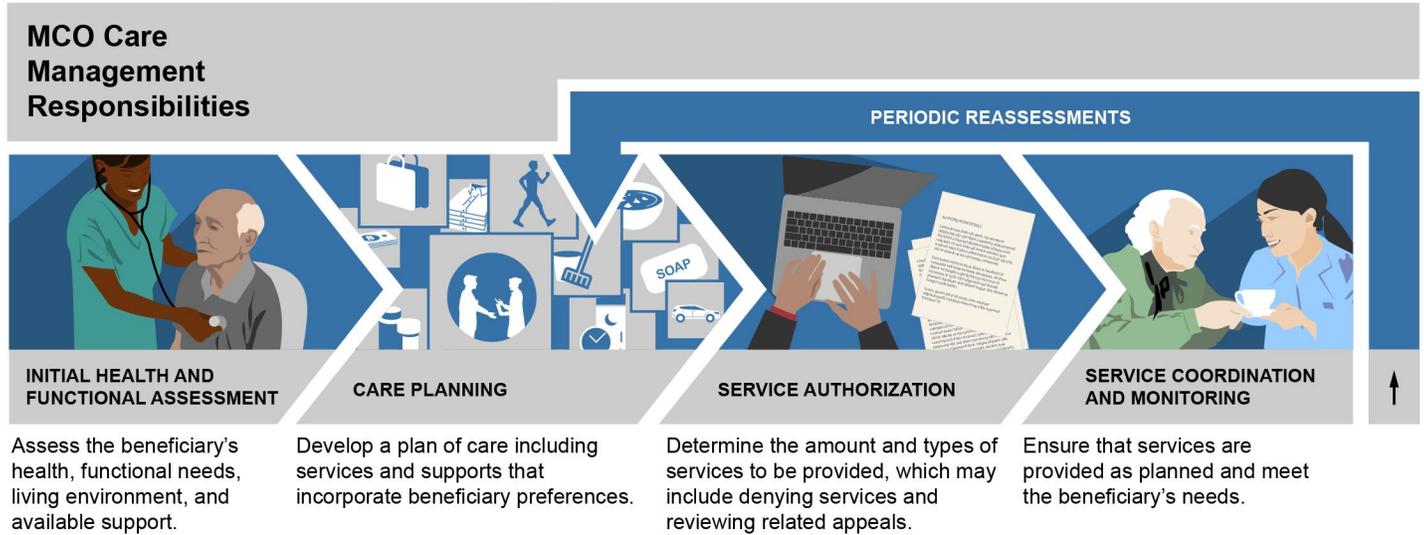
- Managing communication with others
- Transportation and shopping
- Housecleaning and home maintenance
- Managing finances
- Shopping and meal preparation
- Managing medications

Note: Activities of daily living are skills needed to manage one's basic needs. Instrumental activities of daily living are skills that allow individuals to live independently in the community and require more complex planning.

Care Management in MLTSS

Once a beneficiary is determined to be eligible for MLTSS by the state and is enrolled in an MCO, the MCO is responsible for arranging for the beneficiary's service needs, including care management. Care management includes assessing beneficiaries' health, planning for their care, authorizing services, coordinating and monitoring these services, and conducting periodic reassessments of beneficiary health. (See fig. 3.)

Figure 3: Managed Care Organization Care Management Responsibilities for Medicaid Beneficiaries Receiving Long-Term Services and Supports



Source: GAO analysis of state contracts for Medicaid managed care organizations (MCO) covering long-term services and supports. | GAO-21-49

Data table for Figure 3: Managed Care Organization Care Management Responsibilities for Medicaid Beneficiaries Receiving Long-Term Services and Supports

MCO Care Management Responsibilities:

1. Initial Health and functional assessments
2. Care planning
3. Service authorization
4. Service coordination and monitoring
5. Periodic reassessments (restart at 2. Care planning)

States have the primary responsibility for overseeing MCO care management to ensure it meets federal and state requirements. A state's contract with MCOs is the key vehicle for setting minimum requirements for care management. In May 2016, CMS issued new managed care rules that, among other things, included a number of requirements related to MLTSS care management that states must include in their contracts

with MCOs.¹⁷ States are required to submit their contracts to CMS for review and approval. (See table 1.)

¹⁷81 Fed. Reg. 27,498 (May 6, 2016).

Table 1: Summary of Selected Care Management Requirements for State Medicaid Managed Care Contracts

Health assessment	<ul style="list-style-type: none"> Comprehensively assess each long-term services and supports (LTSS) beneficiary using LTSS service coordination requirements.
Care planning	<ul style="list-style-type: none"> Produce a service plan using a person-centered process that offers choices to the individual regarding the services and supports they receive.
Service authorization	<ul style="list-style-type: none"> Ensure consistent application of review criteria for authorization decisions, consult with the requesting provider when appropriate, and authorize LTSS based on a beneficiary’s current needs assessment and person-centered plan of care. Ensure services are sufficient to achieve their purpose and not arbitrarily deny or reduce services.
Service coordination and monitoring	<ul style="list-style-type: none"> Implement procedures to deliver care and coordinate services. Have a quality assessment and performance improvement program that includes mechanisms to assess the quality and appropriateness of care furnished to LTSS beneficiaries, including comparison of services and supports received with those in the plan of care. Participate in efforts by the state to prevent, detect, and remediate critical incidents.^a
Reassessments	<ul style="list-style-type: none"> Reassess the service plan at least every 12 months, when the beneficiary’s needs change, or at the beneficiary’s request.

Source: GAO analysis of Centers for Medicare & Medicaid Services’ 2016 Medicaid managed care final rule. 81 Fed. Reg. 27, 498 (May 6, 2016). | GAO-21-49

^aCritical incidents are events or situations that cause or may cause harm to a beneficiary’s health or welfare, such as abuse, neglect, or exploitation.

States use a variety of approaches to monitor MCO performance, including MLTSS care management. When monitoring their managed care programs, states must comply with federal requirements. The May 2016 final rule includes a set of monitoring requirements under which states must have monitoring systems that address all aspects of their managed care programs, including MCOs’ performance in a broad range of areas, such as care management. States must also use a range of information to improve their programs, but have flexibility in how they collect this information.¹⁸ Examples of state monitoring approaches include the following:

- **Reviewing appeals and grievance data.** CMS requires states to review MCO appeals and grievance systems and make necessary changes to address problems that are identified. Beneficiaries can file an appeal with their MCO in response to a decision to, among other things, reduce services, terminate services, or deny payment for

¹⁸In a 2017 report, we found that states’ monitoring methods varied and included implementing external quality reviews, tracking performance measures, surveying beneficiaries, and reviewing medical charts, among other activities. See [GAO-17-632](#).

services.¹⁹ A beneficiary can file a grievance with an MCO to express dissatisfaction about any matter not covered by appeals. States may collect information from MCOs on the nature, outcome, and total numbers of appeals and grievances.²⁰

- **External quality reviews.** CMS requires states to complete external quality reviews, which must be conducted by an independent organization. External quality reviews must involve assessments of MCOs' compliance with specified regulatory requirements, including those related to quality of care; validation of MCO performance measures; and validation of performance improvement projects.²¹ Reviews can also include other voluntary activities, such as focused studies of quality of care.
- **Operational reviews.** States may choose to monitor MCOs through on-site operational reviews that assess an MCO's performance, policies, and procedures in comparison to contract requirements, other MCOs, or other factors. For example, states may review MCOs' medical management, including utilization and care management; quality improvement; and the delivery of LTSS.

CMS shares the responsibility for oversight of MLTSS with states. CMS is responsible for approving and renewing authority for state MLTSS programs, and for reviewing state assessments of MCO readiness and performance.²² As noted previously, CMS reviews and approves state managed care contracts. It also reviews and approves capitation rates. CMS may also require regular state reporting to monitor program performance. For example, in approving an MLTSS program, CMS may require quarterly or annual reporting, although reporting elements might vary by state. Finally, under the 2016 managed care rule, CMS may,

¹⁹Beneficiaries have the right to request an appeal if they choose and are required to appeal such determinations with the MCO first. Once the beneficiary has exhausted the MCO appeal process, the beneficiary can request a state fair hearing to review the appeal. Prior the 2016 managed care rule, some states allowed beneficiaries to submit appeals to the state and MCO concurrently.

²⁰Our 2017 report found that all states collected some information from MCOs on beneficiary appeals and grievances, but they did not consistently collect information on the nature of these appeals and grievances. See [GAO-17-632](#).

²¹States can exempt certain MCOs from external quality review when the MCO also has a current Medicare contract covering all or part of the same area within the state.

²²States 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.

based upon the recommendation of the agency, deny payment to the state for new enrollees of MCOs when the MCOs are not complying with managed care requirements.²³

MCO Care Management Inconsistently Addressed Selected Beneficiaries' Needs

Certain Care Management Activities Were Routinely Conducted for Selected Beneficiaries, but Follow-Up Actions to Address Needs Were Inconsistent

Our review of 37 beneficiaries' records found that the MCO they were enrolled with routinely conducted certain care management activities. Care coordinators—the MCO staff responsible for providing interventions to improve the quality of care—routinely conducted the following required care management activities:

- **Health assessments.** We found that the MCO's care coordinators generally conducted in-person assessments of beneficiaries at least once a year or as frequently as six times per year. The MCO is contractually required to assess LTSS beneficiaries in person at least once a year, and more frequently for those with a higher level of need.
- **Care plans.** Care coordinators met with beneficiaries to develop individual care plans that documented a beneficiary's living situation, available supports, service needs, and their preferences and goals for care. The MCO is contractually required to develop care plans that are person-centered—that is, tailored to the beneficiary's needs and preferences. MCO care coordinators told us that they generally invite a beneficiary's primary care physician to participate in care planning or provide input, as required by the MCO's contract; however, it was unclear that input was regularly provided. We found that physicians generally did not attend care planning meetings, but care coordinators told us they sometimes communicated with them by phone about a beneficiary's needs.
- **Coordination of services with hospitals.** We found that care coordinators worked with hospitals in the event of a beneficiary's hospital admission and subsequent discharge. Care coordinators are required to ensure the beneficiary's needs are met during the

²³42 C.F.R. § 438.730(e) (2019).

transition back to their residence. Care coordinators for our selected beneficiaries monitored data identifying beneficiaries with emergency department visits and hospital admissions, and reached out to hospital staff who facilitate discharges and to the beneficiary once they returned home. However, we found in one case, despite having reached out to the hospital, the care coordinator was not subsequently informed of the discharge.

While care coordinators fulfilled certain required care management activities, follow-up efforts to address selected beneficiaries' needs and risks was inconsistent in our review of records for the 37 beneficiaries.

- For some beneficiaries, upon identifying a need, care coordinators made notes in the beneficiaries' files indicating that they, for example, helped obtain durable medical equipment, such as walkers and wheel chairs; or helped to arrange medical appointments and transportation to appointments.
- In contrast, there were cases where the care coordinator identified a beneficiary need, but did not indicate how the need would be addressed, or efforts to address the need were not complete even after many months. For example, for two beneficiaries identified as being at risk for falling, there was limited evidence in the care coordination records of efforts to address this risk other than general education about fall risks; subsequently, these beneficiaries experienced falls and in one case hospitalization. For three other beneficiaries, proposals to install equipment and modifications to reduce fall risks had not been implemented as of 5, 7, and 12 months, respectively; two of these beneficiaries experienced multiple falls and visits to the emergency department while they waited for the equipment and modifications.

We also found that the MCO's care coordinators had gaps in information for some beneficiaries who were also covered by Medicare. MCO officials said that a large portion of the MCO's LTSS enrollees are beneficiaries who are dually eligible for Medicare and Medicaid, and many of these beneficiaries have Medicare services covered by other MCOs or provided by providers paid on a fee-for-service basis. For these beneficiaries, the MCO generally lacked utilization data and diagnostic information related to Medicare-covered services, and had to rely on the health assessment with the beneficiary to identify health conditions and current treatment and medications.

Similar to our findings, state and federal reviews of MCO records for beneficiaries—referred to as case files—in several states also identified concerns with MCOs identifying beneficiary needs and addressing them. For example, in its review of MCO health assessments, Texas' Medicaid agency found that some MCOs failed to identify beneficiary needs for skilled nursing services or durable medical equipment, or they identified a need for such services, but failed to provide them. In New Jersey, the Department of Health and Human Services Office of Inspector General found that for 68 of 100 sampled beneficiaries, the Medicaid MCOs did not adequately assess and address beneficiary needs, including seven beneficiaries in one MCO who were at risk for falls.²⁴ Other states that identified similar problems through case file reviews included Arizona, Florida, New York, and Virginia.

The Relationship between the Needs Identified in Health Assessments and the Amount of Authorized Services Was Unclear in Selected Cases

In a number of selected cases, we found incongruence between health assessments completed by care coordinators and the number of personal care hours the MCO authorized. For example, we found cases where the beneficiary experienced a functional decline, or their functional status did not change, but the MCO reduced the number of personal care hours authorized. (See fig. 4.)

²⁴Department of Health and Human Services, Office of Inspector General, *New Jersey Did Not Ensure That Its Managed Care Organizations Adequately Assessed and Covered Medicaid Beneficiaries' Needs for Long-Term Services and Supports*, A-02-17-01018 (June 2020).

Figure 4: Examples of Cases Where Authorized Personal Care Hours Appeared Incongruent with Care Coordinator Assessments of Medicaid Beneficiaries' Functional Needs



Source: GAO analysis of beneficiary records from a managed care organization. | GAO-21-49

Data table for Figure 4: Examples of Cases Where Authorized Personal Care Hours Appeared Incongruent with Care Coordinator Assessments of Medicaid Beneficiaries' Functional Needs

Beneficiary 1: 70 year old with both mental health and chronic physical health conditions

Assessment indicated functional decline

Assessments conducted by the managed care organization's (MCO) care coordinator reflected a decline in health and functional status in fall of 2019, as well as a need for supervision in early 2020.^a This occurred shortly after the beneficiary had multiple hospital admissions over the course of several months, and an indication of multiple falls.

MCO reduced personal care hours

The beneficiary was authorized for 42 hours per week in November 2019. They requested an increase to 84 hours per week in February 2020, but the beneficiary's hours were decreased to 38.5 hours a week. The MCO determined that the requested amount was greater than the amount of time required to complete these tasks and the provider did not submit detail on the amount of time needed.

Beneficiary 2: 65+ year old with a heart condition, cancer, and short term memory impairment

Assessment indicated that beneficiary needed maximum hours of assistance

The beneficiary was assessed by the care coordinator in June 2019. The care coordinator determined that the beneficiary needed the maximum hours of assistance and had some difficulty with short-term memory impairment.

MCO reduced personal care hours

Prior to the assessment, the beneficiary had been receiving 56 hours per week. Upon requesting an increase to 59.5 hours per week in July 2019, the MCO reduced approved hours to 35 hours per week. The MCO determined that requested hours were more than what was needed and that the criteria for needing supervision was not met, because the beneficiary could call their family member who they lived with for help.

Beneficiary 3: 60+ year old with a range of chronic disease diagnoses

Assessment of functional need remained the same

The beneficiary was assessed twice between April and October of 2019. The care coordinator did not indicate a change in functional status over this time.

MCO reduced personal care hours

The beneficiary had been receiving 51 hours per week, and requested an increase to 56 hours per week. The MCO reduced hours to 31.5 hours per week. The MCO acknowledged that the beneficiary had been recently hospitalized, but that their level of care needs had not changed, and that the 51 hours weekly the beneficiary had originally been receiving were “in excess of guidelines.”

Notes: Examples were pulled from a record review for 37 Medicaid beneficiaries enrolled in a managed care organization (MCO) in one state in 2019. Records reviewed included care coordinator health assessments, care plans, and contact notes of conversations with beneficiaries and others, as well as personal care service authorizations, which included records of the number of hours of care requested by beneficiaries and the MCO’s determination, for the period beginning with each beneficiary’s enrollment through February 2020.

^aSupervision may be required in certain cases where there is a need for someone to be present because the beneficiary cannot safely be left alone.

Summary of MCO Appeals Process

The managed care organization (MCO) appeal process is as follows:

- MCO provides a notice to beneficiaries when it denies or partially denies a request for a certain number of personal care hours and explains appeal rights.
- Beneficiary submits appeal.
- MCO staff, including a medical director or other physician, reviews relevant documentation and upholds, partially upholds, or overturns denial.
- MCO notifies beneficiary of decision and right to request a state fair hearing.

Source: Federal guidance and MCO policies. | GAO-21-49

Cases in which beneficiaries appealed the MCO’s decision to reduce personal care hours raised further questions about the relationship between the MCO’s assessments and authorizations. (See sidebar about the appeals process.) In several cases we reviewed where the beneficiary appealed a reduction in hours, the MCO upheld the denial decision based on lack of proper documentation rather than the assessment of the beneficiaries’ needs. Among our sample of 37 beneficiaries, we identified eight beneficiaries who filed one or more appeals for a total of 11 appeals. The MCO upheld its original denial in 10 of these appeals and partially overturned its decision for one—providing some, but not all, of the beneficiary’s requested hours. (See table 2 for two examples.)

Table 2: Examples of Cases Where a Medicaid Beneficiary Appealed the Managed Care Organization’s Decision to Reduce Personal Care Hours

Case	What happened?
Case 1	<p>Change in personal care hours: The number of personal care hours went from 59 hours per week to 17.5 hours per week, a decrease of 41.5 hours or 70 percent. In the months prior to this decrease, the care coordinator’s notes indicated that the beneficiary continued to have significant health issues resulting in missing school and being home 50 percent of the time.</p> <p>Appeal: The beneficiary’s family appealed to the MCO twice, and in both cases the MCO upheld its decision to reduce the hours. The MCO determined that while the beneficiary qualified for personal care hours to assist with activities of daily living, the beneficiary did not qualify for 41.5 additional hours for supervision according to state guidelines. The basis for this determination was that the family caregiver submitted insufficient documentation of work hours and did not submit other documentation related to the beneficiary’s educational status.</p>
Case 2	<p>Change in personal care hours: The number of personal care hours went from 35 hours per week to 11.25 hours per week, a decrease of 23.75 hours or 68 percent.</p> <p>Appeal: The beneficiary appealed to the MCO, but the MCO upheld its original decision on the basis that the hours requested were more than was needed to assist with bathing, dressing, eating/feeding, and toileting. In addition, the MCO found that hours for supervision were not specifically requested. The next month the MCO was notified that the beneficiary was hospitalized. That same month, care coordinator notes indicate the family caregiver expressed fear of the beneficiary due to aggressive, physical behavior, and mentioned episodes of choking others. Several months after that, the care coordinator’s assessment described the beneficiary as requiring constant supervision due to poor judgement, and as being compulsive and combative, and a possible flight risk. Subsequently, the MCO authorized an increase to 30 hours of personal care per week.</p>

Source: GAO analysis of beneficiary records from a managed care organization (MCO). | GAO-21-49

Beneficiary case file reviews and other monitoring efforts conducted by several state Medicaid agencies have raised similar questions about MCO authorizations for LTSS. For example, between 2018 and 2019, Virginia’s Medicaid agency found that three of six MCOs had inappropriately reduced services for 33 percent to 53 percent of beneficiary case files reviewed. All three MCOs either denied or reduced services for beneficiaries before seeking additional information that may have justified the beneficiary’s request, as required by contract. The state further found that there was lack of follow-up on the status of beneficiaries whose services had been reduced. Other states that identified problems with the adequacy of MCO authorizations for LTSS included Arizona, Florida, New York, and Texas.

Selected States Identified Significant Problems with MCO Care Management, though States

May Not Be Identifying the Full Extent of Problems

Selected States Found Problems with MCO Care Management, Some of Which Were Systemic and Occurred over Multiple Years

Through various monitoring approaches, all six selected states identified performance problems within an element of MCO care management; these problems ranged from MCO noncompliance with assessment and care planning to inadequate care coordination and monitoring of service provision to beneficiaries. (See fig. 5.) States identified these problems through, for example, external quality reviews and operational reviews.

Figure 5: Problems in Managed Care Organization (MCO) Performance of Care Management for Medicaid Beneficiaries Receiving Long-Term Services and Supports (LTSS), Identified by Six Selected States

Problem area and description	States identifying the problem	Examples
 <p>Assessments and Care Planning</p> <p>MCOs did not follow person-centered requirements for assessments and care planning.^a</p>	<p>Arizona Florida Iowa New York Texas</p>	<p>Between 2016 and 2018, in quarterly reviews, Florida found five of six MCOs did not consistently contact beneficiaries and update care plans when necessary. For example, one MCO did not have regular face to face meetings with beneficiaries to review or update their care plan for 29 to 83 percent of cases reviewed.</p> <p>In 2017 and 2018, Iowa found that for the two MCOs it assessed, both had low compliance with multiple aspects of person-centered planning. For example, one MCO complied with the requirement that beneficiaries choose the lead of their care team in 18 percent of cases, and another MCO in 54 percent of cases.</p>
 <p>Service Authorizations</p> <p>MCO authorizations of services were insufficient or the process did not meet state requirements.</p>	<p>Arizona Florida New York Texas Virginia</p>	<p>In 2020, Arizona found that the MCO responsible for beneficiaries with developmental disabilities had wrongly stopped approving all speech augmentation devices used for aiding communication. The beneficiaries, mostly children, did not receive timely and accurate notices regarding the loss of these benefits, which hindered their ability to file appeals.</p> <p>In 2018, New York found that an MCO had inappropriately reduced personal care services for 88 percent of cases reviewed. There were no identified changes in the beneficiaries' medical conditions, mental conditions, or social circumstances that would have justified the reductions.</p>
 <p>Service Coordination and Monitoring</p> <p>MCOs had deficiencies in coordinating and monitoring beneficiaries' quality or access to care.</p>	<p>Arizona Iowa Florida New York Texas</p>	<p>In 2019, Iowa found deficiencies in the number of care coordinators available for one MCO. On average, the MCO assigned 60 beneficiaries to each coordinator, which is a third more than other MCOs. Additionally, 37 percent of the MCO's LTSS care coordinator positions were vacant.</p> <p>In 2018 and 2019, Arizona found that three of four MCOs failed to report to the state multiple quality of care concerns. Some of these concerns involved significant medication errors, abuse, or caused harm. One MCO failed to report over 1,500 of these concerns.</p>
 <p>Timeliness of Key Activities</p> <p>MCOs did not meet timeliness goals for key care management tasks.</p>	<p>Arizona Florida Iowa New York Texas Virginia</p>	<p>In 2017 and 2018, Texas found that of the two MCOs it reviewed, neither contacted beneficiaries to ensure approved services were in place within 4 weeks of completing the plan of care for 66 percent of cases reviewed in one MCO and 39 percent in another MCO.</p> <p>Between 2017 and 2019, Virginia found that three of its six MCOs were not meeting requirements for timely authorizations of services. Delays for one MCO led providers to consider suspending services for beneficiaries.</p>

Source: GAO analysis of state information. | GAO-21-49

Data table for Figure 5: Problems in Managed Care Organization (MCO) Performance of Care Management for Medicaid Beneficiaries Receiving Long-Term Services and Supports (LTSS), Identified by Six Selected States

Problem area and description	States identifying the problem	Examples
Assessments and Care Planning: MCOs did not follow person-centered requirements for assessments and care planning. ^a	Arizona Florida Iowa New York Texas	Between 2016 and 2018, in quarterly reviews, Florida found five of six MCOs did not consistently contact beneficiaries and update care plans when necessary. For example, one MCO did not have regular face to face meetings with beneficiaries to review or update their care plan for 29 to 83 percent of cases reviewed. In 2017 and 2018, Iowa found that for the two MCOs it assessed, both had low compliance with multiple aspects of person-centered planning. For example, one MCO complied with the requirement that beneficiaries choose the lead of their care team in 18 percent of cases, and another MCO in 54 percent of cases.
Service Authorizations: MCO authorizations of services were insufficient or the process did not meet state requirements.	Arizona Florida New York Texas Virginia	In 2020, Arizona found that the MCO responsible for beneficiaries with developmental disabilities had wrongly stopped approving all speech augmentation devices used for aiding communication. The beneficiaries, mostly children, did not receive timely and accurate notices regarding the loss of these benefits, which hindered their ability to file appeals. In 2018, New York found that an MCO had inappropriately reduced personal care services for 88 percent of cases reviewed. There were no identified changes in the beneficiaries' medical conditions, mental conditions, or social circumstances that would have justified the reductions.
Service Coordination and Monitoring: MCOs had deficiencies in coordinating and monitoring beneficiaries' quality or access to care.	Arizona Iowa Florida New York Texas	In 2019, Iowa found deficiencies in the number of care coordinators available for one MCO. On average, the MCO assigned 60 beneficiaries to each coordinator, which is a third more than other MCOs. Additionally, 37 percent of the MCO's LTSS care coordinator positions were vacant. In 2018 and 2019, Arizona found that three of four MCOs failed to report to the state multiple quality of care concerns. Some of these concerns involved significant medication errors, abuse, or caused harm. One MCO failed to report over 1,500 of these concerns.
Timeliness of Key Activities:	Arizona Florida Iowa New York Texas Virginia	In 2017 and 2018, Texas found that of the two MCOs it reviewed, neither contacted beneficiaries to ensure approved services were in place within 4 weeks of completing the plan of care for 66 percent of cases reviewed in one MCO and 39 percent in another MCO. Between 2017 and 2019, Virginia found that three of its six MCOs were not meeting requirements for timely authorizations of services. Delays for one MCO led providers to consider suspending services for beneficiaries.

Notes: This figure reflects findings from state Medicaid agency monitoring efforts, which include among other things reviews of MCO operations and external quality reviews, from state fiscal year 2017 through January 2020 in selected states. For Texas, the figure also reflects findings from the state's Office of Inspector General. Selected states included Arizona, Florida, Iowa, New York, Texas, and Virginia.

^aPerson-centered planning promotes self-determination, includes an interdisciplinary team of professionals with expertise in long-term services and supports, actively engages the beneficiary and individuals of their choice, and addresses how needs will be met through medical and non-medical services and supports from the MCO or community on an ongoing basis. MCOs must follow person-centered planning requirements when assessing beneficiaries and developing their care plans.

For five of the selected states (Arizona, Florida, Iowa, Texas, and Virginia), the state identified care management problems that occurred over multiple years.²⁵ For example:

- **Arizona.** Arizona identified problems across multiple MCOs in 2015, 2016, 2017, and 2019. These problems included lack of follow-up, untimely service authorizations for beneficiaries, and transportation barriers. Further, the state found persistent issues with the MCO responsible for providing LTSS to beneficiaries with developmental disabilities.²⁶ For example, between 2015 and 2018, the average beneficiary case load ratio for care coordinators gradually increased, leading to care coordinators taking on an average of nine more beneficiaries with developmental disabilities than the 40 that Arizona permits at any given time. A quality audit the state conducted in 2018 found that the MCO neglected to conduct comprehensive quality of care investigations for multiple incidents; it failed to clinically evaluate and resolve over 27,000 quality incident reports, including medication errors; and it neglected to report serious incidents like sexual assaults or attempted suicides to the proper agency.
- **Texas.** Texas identified problems across multiple MCOs in 2014, 2015, 2016, 2017, 2018, and 2019. These problems included a lack of timely completion of health assessments, lack of follow-up and care coordination, and challenges providing necessary care. For example, Texas found that two MCOs did not provide sufficient personal care services for 66 percent or more of beneficiaries in 2014. In a subsequent review in 2017, the state found that four MCOs had challenges with multiple issues, such as documenting beneficiary needs in service plans, initiating services authorized in the service plan, and meeting timeliness goals for assessments of beneficiaries. In 2018, the state found problems in how an MCO was authorizing

²⁵States with long-standing MLTSS programs include Arizona (1989), Texas (1998), and New York (1998). States with newer programs are Florida (2013), Iowa (2016), and Virginia (2017).

²⁶In Arizona, only one MCO provides LTSS to beneficiaries with developmental disabilities. This MCO is part of a state agency that is under contract with the state Medicaid department.

private duty nursing services.²⁷ The MCO's practices conflicted with state requirements and the MCO's own internal policies by implying that services could be reduced or denied based on a parent's or guardian's ability to perform the nursing task. Texas found improvement in some of these areas like conducting timely assessments during its 2019 review of MLTSS care management, but there continued to be problems with ensuring timely provision of services.

States varied in how they responded to problems with MCO care management. All of the selected states required MCOs to carry out corrective actions to address care management problems. For example, of the three MCOs it reviewed, Arizona found that all three did not ensure beneficiaries received services in the community within the required time frames. As a result, Arizona required the MCOs to develop corrective action plans that demonstrated how their policies or procedures would ensure timely service delivery. Texas found that an MCO's policy on private duty nursing conflicted with state requirements. As a result, Texas required the MCO to create a corrective action plan that revised its internal policies and procedures to match state requirements and evaluated the impact of the policy on beneficiaries. Three states (Florida, Iowa, and Texas) required MCOs to pay financial penalties.²⁸ States have also used other strategies. For example, officials in Virginia stated they sometimes required care management improvement plans or provided technical assistance when problems arose. In New York, officials stated they provided guidance on implementing person-centered requirements, because MCOs faced challenges in implementing all the elements of person-centered planning.

Two selected states with persistent problems made significant changes to their MLTSS programs in response to external investigations.

- In Arizona, the MCO that provides LTSS to individuals with developmental disabilities was responsible for the care management of a long-term care facility resident who was incapacitated and found

²⁷Private duty nursing is a type of home and community based service where nurses provide individualized, continuous care to beneficiaries in their home or in the community.

²⁸States varied in how they impose financial penalties. Florida has an automatic, systematic process for imposing financial penalties for certain care management problems, such as not conducting face-to-face meeting with beneficiaries. Virginia has a point system where MCOs accumulate points for not complying with contract requirements more generally. MCOs pay financial penalties depending on the number of points they have accumulated.

to be pregnant after sexual abuse in late 2018. The police initiated an investigation, and the governor established a task force in February 2019 to prevent future abuse and neglect in MLTSS programs.

- In Texas, a media outlet released a series of investigative reports beginning in June 2018 about MLTSS beneficiaries being denied or lacking access to necessary care. These reports led to a state hearing and changes that improved the oversight of MLTSS programs, such as hiring more individuals dedicated to monitoring MCOs.

Three of the selected states also reported making program changes as a result of litigation related to care management issues. (See table 3).

Table 3: Examples of Litigation Related Changes to Care Management for Managed Long-Term Services and Supports for Medicaid Beneficiaries in Selected States

State	Issue	Outcome
Arizona	In 2009, adult Medicaid beneficiaries with disabilities claimed they were denied incontinence briefs, which providers prescribed to prevent skin infections. Beneficiaries stated the incontinence briefs are necessary to be integrated into the community. However, the state policy only covered this product for those over 21 to treat skin infections, not prevent them.	In 2014, the Arizona Medicaid agency's policy was determined to violate federal Medicaid law. As a result the state now covers incontinence briefs for managed long-term services and supports (MLTSS) beneficiaries where medically necessary for preventing or treating skin infections.
Florida	In 2015, Medicaid beneficiaries claimed that as a result of the state's implementation and oversight of home and community based services, they were denied medically necessary services and were unable to fully participate in the service planning process due to the lack of transparency and clarity in available information which placed them at risk of being in a nursing home.	In 2016, the Florida Medicaid agency agreed to adopt long term care policies that included requirements for managed care organization (MCO) health assessment and care planning criteria and processes, and for communications to beneficiaries about reductions and denials of care, among other things. The Medicaid agency also agreed to conduct additional monitoring of MCOs, such as case file reviews and surveys of MLTSS beneficiaries.
New York	In 2016, Medicaid beneficiaries claimed that the MCO engaged in systemic practices of threatening to reduce or actually reducing, and of denying or refusing to consider requests for increases in LTSS based on arbitrary limits, and without the timely and adequate notice required by law, and that the state failed to ensure the MCO complied with Medicaid requirements.	In 2018, the MCO agreed to comply with Medicaid requirements and refrain from reducing or threatening to reduce LTSS except in limited circumstances. The New York State Department of Health agreed to maintain a survey and audit schedule to assess MCO compliance with MLTSS requirements, among other things.

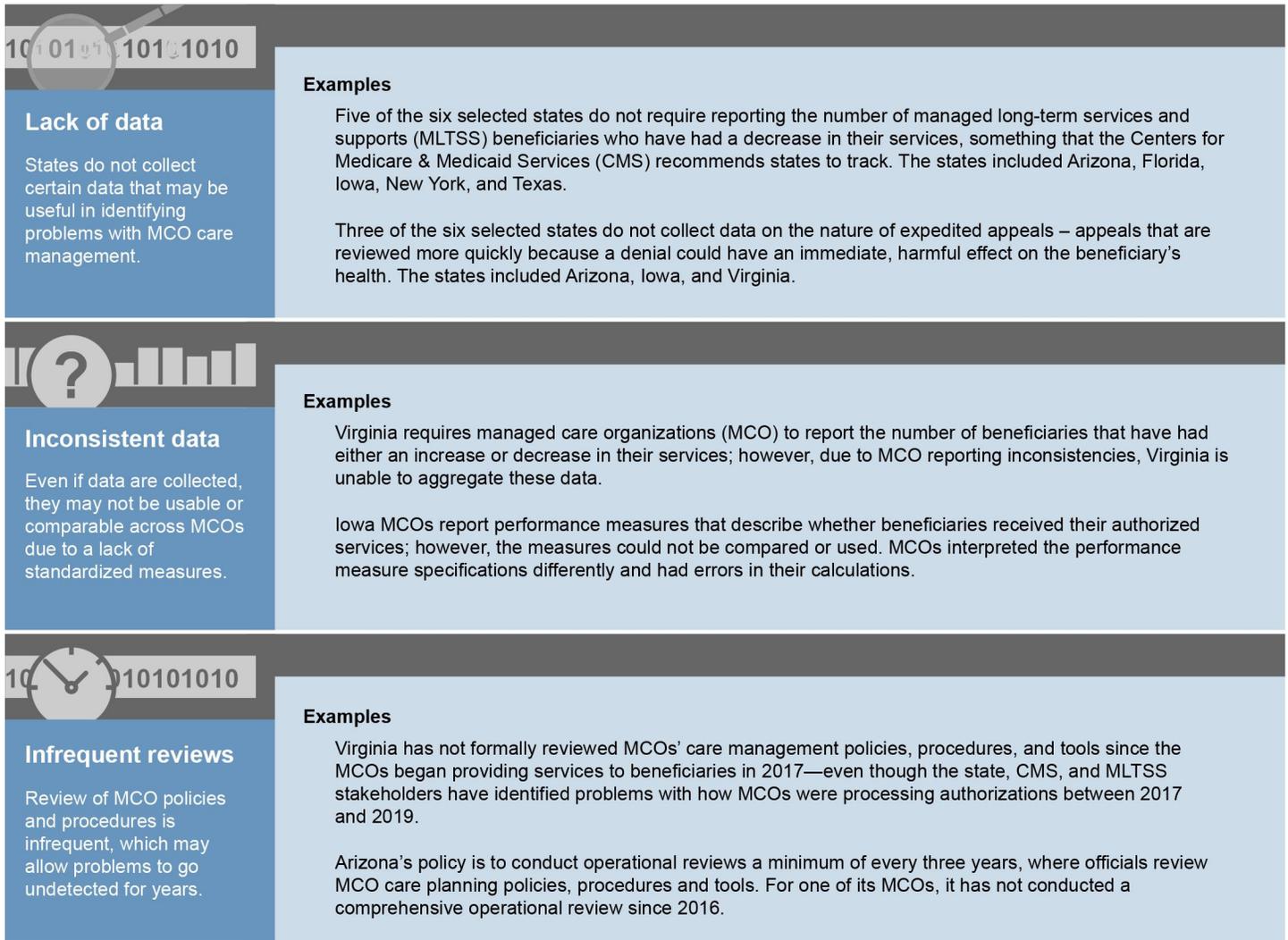
Source: GAO summary of court filings concerning state Medicaid programs. | GAO-21-49

Selected States' Care Management Problems May Be Underestimated

Selected states may not be identifying all care management problems due to limitations in the information they collect or use to monitor MCOs. For example, we found that selected states did not always collect certain

data, collected inconsistent data, or conducted infrequent reviews of MLTSS programs. (See fig. 6.)

Figure 6: Examples of Limitations in the Information Selected States Used or Collected to Monitor Managed Care Organization Care Management



Source: GAO analysis of state information. | GAO-21-49

Data table for Figure 6: Examples of Limitations in the Information Selected States Used or Collected to Monitor Managed Care Organization Care Management

Limitation	Example
Lack of data: States do not collect certain data that may be useful in identifying problems with MCO care management.	<p>Five of the six selected states do not require reporting the number of managed long-term services and supports (MLTSS) beneficiaries who have had a decrease in their services, something that the Centers for Medicare & Medicaid Services (CMS) recommends states to track. The states included Arizona, Florida, Iowa, New York, and Texas.</p> <p>Three of the six selected states do not collect data on the nature of expedited appeals – appeals that are reviewed more quickly because a denial could have an immediate, harmful effect on the beneficiary’s health. The states included Arizona, Iowa, and Virginia.</p>
Inconsistent data: Even if data are collected, they may not be usable or comparable across MCOs due to a lack of standardized measures.	<p>Virginia requires managed care organizations (MCO) to report the number of beneficiaries that have had either an increase or decrease in their services; however, due to MCO reporting inconsistencies, Virginia is unable to aggregate these data.</p> <p>Iowa MCOs report performance measures that describe whether beneficiaries received their authorized services; however, the measures could not be compared or used. MCOs interpreted the performance measure specifications differently and had errors in their calculations.</p>
Infrequent reviews: Review of MCO policies and procedures is infrequent, which may allow problems to go undetected for years.	<p>Virginia has not formally reviewed MCOs’ care management policies, procedures, and tools since the MCOs began providing services to beneficiaries in 2017—even though the state, CMS, and MLTSS stakeholders have identified problems with how MCOs were processing authorizations between 2017 and 2019.</p> <p>Arizona’s policy is to conduct operational reviews a minimum of every three years, where officials review MCO care planning policies, procedures and tools. For one of its MCOs, it has not conducted a comprehensive operational review since 2016.</p>

Note: This figure reflects analysis of information reported by state Medicaid agencies on their monitoring practices as of the end of state fiscal year 2019, and documentation of state monitoring findings from state fiscal year 2017 through January 2020 in selected states, which included Arizona, Florida, Iowa, New York, Texas, and Virginia.

CMS’s Oversight of State Implementation of MLTSS Requirements Is Limited, Hindering Its Ability to Hold States and MCOs Accountable for Access and Quality Problems

CMS Has Not Assessed the Effectiveness of State Implementation of Monitoring and Beneficiary Protection

Requirements, and Did Not Detect Access and Quality Problems

We found that CMS has not systematically overseen whether states have effectively implemented requirements for monitoring their managed care programs, which may have allowed problems in MLTSS programs to persist. The 2016 final rule requires states to

- have monitoring systems that address all aspects of their managed care programs, including MCOs' performance in a broad range of areas, such as care management, availability and accessibility of services, appeals and grievance systems, and quality improvement; and
- use multiple types of data—such as beneficiary grievance and appeal logs, external quality review findings, and performance data from the beneficiary support system—to improve their programs.

We also found that CMS has not monitored whether states have effectively implemented two beneficiary protection requirements—state beneficiary support systems and MLTSS stakeholder advisory groups. States must have beneficiary support systems that provide specific protections for beneficiaries who use LTSS, such as assistance, upon request, with appealing MCO decisions to reduce or deny care.²⁹ States must also establish an advisory group to ensure that the views of MLTSS beneficiaries and other stakeholders are addressed as a part of state oversight.³⁰ We identified potential problems with how several of our selected states had implemented these protections. For example, according to state officials, as of July 2020, Iowa's support system had 1.5 full-time equivalent (FTE) staff to provide LTSS supports for a program with roughly 40,000 beneficiaries—a decrease from 2017 when it had three FTEs; this raises questions about whether there were enough

²⁹For beneficiaries who use or wish to use LTSS, states' beneficiary support systems must provide, for example, an access point for complaints about enrollment and access to services; education on grievance and appeal rights and resources, and state fair hearings; and help, upon request, with navigating the grievance and appeal process. Beneficiary support systems are to use program data to provide guidance to the state Medicaid agency on the identification and resolution of systemic issues.

³⁰Specifically, states must ensure the views of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders are solicited and addressed during design, implementation, and oversight of a MLTSS program. The group's composition and meeting frequency must be sufficient to ensure meaningful stakeholder engagement.

staff to support beneficiaries.³¹ In addition, Iowa, New York, and Virginia had not established MLTSS-specific stakeholder groups, raising questions about the effectiveness of the states' MLTSS stakeholder engagement efforts.³²

One way that CMS could have been collecting information on states' monitoring systems and beneficiary protections is through new state reports that were required under the final rule; however, this requirement for state reporting has not yet been implemented. Under the final rule, based on their monitoring efforts, states must submit to CMS new annual reports on topics such as the results of sanctions imposed on MCOs.³³ (See text box.) States are to begin submitting the reports after CMS issues guidance on the reports' content and format. However, as of July 2020—over 4 years since the final rule was issued—CMS had not issued that guidance, so states have not begun submitting them. CMS officials told us they were developing the guidance and a new reporting tool for the reports, which they hoped to release in early 2021. Although these reports are required to include information on MLTSS programs, CMS officials had not yet determined the extent to which such information will be included in the reports. In the absence of those reports, CMS has not implemented other procedures to systematically oversee the effectiveness of states' monitoring programs and beneficiary protections.

Overview of State Annual Reports Required by CMS's 2016 Medicaid Managed Care Final Rule

In its 2016 final rule, the Centers for Medicare & Medicaid Services (CMS) required states to submit annual reports on their managed care programs in order to (1) address the fragmented information CMS was receiving about those programs, and (2) improve CMS's oversight efforts. CMS believed the annual reports would provide valuable and timely information on the operation of managed care programs, and improve transparency for consumers, providers, and other stakeholders. Under the final rule, states must, among other things,

³¹According to state officials, one of the three FTEs was a program manager, a position that was eliminated in 2017. From January through March 2020, Iowa beneficiaries sought help with issues such as LTSS services being reduced, denied or terminated; not receiving approved services due to a lack of providers or staff; and problems with case managers, such as delayed response times. See Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program, *Managed Care Ombudsman Program Quarterly Report, Year 4, Quarter 4 (January 1 - March 31, 2020)*.

³²For example, New York officials told us they meet with Medicaid advocate groups, but have not established an MLTSS stakeholder group. Iowa has an advisory council that addresses Medicaid services generally, but does not have a MLTSS-specific stakeholder group.

³³States are to submit reports no later than 180 days after each contract year for each managed care program the state administers. A state's initial report will be due after the contract year following CMS's release of guidance on the report's form and content.

Report to CMS on information such as

- grievance, appeals, and state fair hearings;
- managed care organization (MCO) performance on quality measures;
- results of any state-imposed sanctions or corrective action plans, other state interventions;
- availability and accessibility of covered services, including network adequacy standards;
- beneficiary support system activities and performance; and
- for managed long-term services and supports (MLTSS) programs, any factors in the delivery of long-term services and supports not addressed by other required information.

Share reports with

- CMS; the state Medical Care Advisory Committee; and the public, via a state website; and
- for MLTSS programs, the state MLTSS stakeholder group required by the final rule.

Source: 42 C.F.R. § 438.66(e) (2019). | GAO-21-49

CMS officials told us that while they do not have mechanisms to systematically assess states' implementation of required monitoring systems and beneficiary protections, they use other methods to oversee state MLTSS programs. For example, CMS officials conduct reviews when states seek to extend their programs, which may happen every 2 to 5 years. Officials said they also rely on state reviews of MCO readiness required when states contract with a new MCO or when an MCO will provide covered services to a new eligibility group. They also use states' external quality reviews and information that states report periodically according to the terms of the MLTSS program approval.³⁴ In addition, they said that routine contacts with states and MCOs, as well as episodic input from stakeholders, are other sources of monitoring information.

We found that CMS's oversight approach was not effective in detecting and resolving MLTSS access and quality problems. CMS officials told us they had become aware of problems in multiple MLTSS programs and had engaged with the states to resolve them.³⁵ In several of these cases, however, CMS officials learned of the problems after receiving complaints from beneficiaries, family members or other stakeholders, or through media reports—and not through their regular oversight methods. In

³⁴When 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. For example, 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. See [GAO-17-632](#).

³⁵CMS officials provided examples of becoming aware of issues and working with the state toward resolution in states such as Arizona, Kansas, Michigan, New Jersey, Texas, Virginia, and Wisconsin.

another case, CMS officials were not aware of problems until we informed the agency about them. For example:

- **Virginia.** Through ongoing complaints from a few beneficiaries, family members, and caregivers, CMS officials learned of a potential problem with inappropriate service authorizations resulting in reductions in beneficiaries' personal care services. CMS officials said they communicated with state officials about this issue throughout 2017 and 2018, and the state agreed in late 2018 to conduct an audit of the appropriateness of MCO authorizations of personal care hours. The state issued corrective action plans to two of the state's MCOs in 2019, according to CMS officials.
- **New Jersey.** CMS officials told us that in February 2020 they learned from media reports that New Jersey had temporarily frozen enrollment in one MCO. They spoke with state officials, who shared the operational challenges of the MCO, which affected MLTSS services. The state had found, for example, that the MCO was noncompliant with requirements for face-to-face visits and had developed care plans that were not based on patient-centered principles. As of July 2020, CMS officials were holding biweekly calls with the state to address unresolved problems and to ensure that problems that have been resolved do not reoccur in the future.
- **Arizona.** CMS officials told us they were not aware of multiple problems the state identified with MCOs' care management and monitoring practices until we informed CMS about the problems in June 2020. For example, according to CMS officials, the state did not inform them of multiple problems with the MCO responsible for providing LTSS to beneficiaries with developmental disabilities. Arizona found in 2018 that this MCO failed to report over 1,500 quality of care concerns to the state and, as noted earlier, failed to evaluate about 27,000 quality incident reports. The state also had not informed CMS of problems with other MCOs' care management, including 2019 findings of untimely provision of services, and MCOs not following care planning requirements. CMS officials told us that they plan to contact state officials to ensure that their follow-up actions were appropriate and to provide technical assistance as needed. CMS officials told us they were aware of other problems with the MCO responsible for individuals with developmental disabilities. According to the officials, CMS learned of those problems from sources other

than the state, and after learning of those problems the agency worked with the state to address them.³⁶

Our prior work on MLTSS programs also pointed to the consequences of insufficient CMS and state oversight—as well as actions CMS can take to help address quality and access problems. We reported in 2017 that in response to hundreds of complaints from beneficiaries, providers, and advocates voiced directly to CMS, the agency conducted an on-site review of Kansas' comprehensive managed care program.³⁷ CMS found systemic, longstanding deficiencies in Kansas' oversight that CMS had not previously identified through the state's required reporting. CMS determined that the deficiencies put beneficiaries' health and safety at risk and immediate action was required.³⁸ The agency required Kansas to implement a corrective action plan that was focused largely on the provision of MLTSS. Since 2017, CMS officials said they have communicated with state officials about how they are addressing deficiencies. In July 2020, CMS officials said that Kansas still had not met all the requirements specified in the corrective action plan, which remained open.

In the same report, we also found that CMS lacked sufficient information from states to monitor access and quality in MLTSS programs. We recommended improvements, but as of July 2020, CMS had made minimal progress in addressing our recommendation.³⁹ (See text box.)

³⁶CMS officials said that in 2019 they received complaints from beneficiaries about access problems and, as a result, held calls with state officials about addressing those problems. CMS officials said they also were aware of the case mentioned earlier, in which a beneficiary enrolled with the MCO, who was a long-term care facility resident and incapacitated, was found to be pregnant in 2018. The state did not alert CMS to that case, but CMS officials said that upon learning of it, they worked with the state and made referrals to the HHS Office of Inspector General and the Department of Justice.

³⁷See [GAO-17-632](#).

³⁸CMS conducted its detailed on-site review in October 2016, after receiving complaints between late 2015 and mid-2016. CMS requested documentation from the state beyond what the state is required to report. CMS found that the state agency's oversight of its MCOs had diminished since the start of the managed care program. See [GAO-17-632](#).

³⁹In 2017, we also found that CMS was not consistently requiring states to report on whether their MLTSS payment structures were achieving program goals. We recommended that CMS require all states to collect and report on progress toward achieving goals, such as whether the program enhances the provision of community-based care. HHS concurred with our recommendation, but as of June 2020 had made minimal progress addressing it. See [GAO-17-145](#).

Prior GAO Findings and Recommendation to Improve CMS Oversight of MLTSS Programs

In 2017, we found that the Centers for Medicare & Medicaid Services (CMS) did not always require selected states to report information needed to monitor access and quality in state managed long-term services and supports (MLTSS) programs. For example:

- CMS could not directly monitor the degree to which critical incidents were occurring in some states or how the states were tracking and resolving those incidents; and
- CMS may have been unable to identify trends in the appeals that managed care organizations (MCO) had denied, and any MCOs that were inappropriately reducing or denying services.

We concluded that without additional information from states, CMS's ability to monitor programs, identify potential problems, and take action may be limited. We recommended that CMS obtain key information to oversee states' efforts to monitor beneficiary access to quality services. The agency concurred with the recommendation, but as of July 2020 was still developing guidance for what information states would report.

Source: GAO, *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs*, [GAO-17-632](#) (Washington, D.C.: Aug. 14, 2017); and CMS information. | GAO-21-49

CMS's Limited Actions to Assess the Effectiveness of State Efforts Reflects the Broader Absence of a Strategy for Overseeing MLTSS Programs

CMS's limited actions to assess the effectiveness of states' implementation of monitoring systems and beneficiary protections reflects a broader area of concern—namely, that the agency lacks an overarching strategy for overseeing MLTSS programs. In the preamble to the 2016 final rule and other guidance, the agency has cited the unique needs of beneficiaries receiving LTSS, as well as the importance of states' monitoring MCOs' provision of care to this population. However, CMS has not developed a specific strategy for how it will oversee access and quality in MLTSS programs. Instead, CMS has relied on its approach for overseeing Medicaid managed care generally, which relies, in part, on states voluntarily disclosing problems to CMS.⁴⁰ As we noted earlier, this has led to CMS being unaware of some significant access and quality problems and, without a targeted strategy, CMS risks being unable to effectively identify and help address access and quality of care issues beneficiaries may face. CMS's lack of a strategy is inconsistent with federal internal controls for monitoring activities; identifying and responding to risks; and using quality information.⁴¹

In addition, CMS has not assessed the nature and extent of MLTSS access and quality problems across states, including problems pertaining

⁴⁰Medicaid managed care programs can include acute care, behavioral health, and other types of services.

⁴¹See [GAO-14-704G](#).

to care management. While CMS officials have learned of significant access and quality problems with MLTSS programs in a number of states, they have not performed a systematic assessment across all states with MLTSS programs and, as of July 2020, had no plans to do so. States have conducted reviews with findings that could inform such an assessment, but CMS has not always obtained that information from the states, such as in the case of Arizona. Without more robust information on the nature and extent of the problems, CMS is not well-positioned to develop a strategy and target its oversight—hindering its ability to hold states and MCOs accountable.⁴² CMS's lack of an assessment of MLTSS access and quality problems is inconsistent with federal internal controls for monitoring activities; identifying and responding to risks; and using quality information.

In July 2020, CMS officials told us they had recently convened a new workgroup focused on oversight of MLTSS. This workgroup had begun by reviewing the roles of various CMS offices in the oversight of MLTSS programs. The workgroup plans to assess the agency's existing MLTSS oversight tools to determine where additional efforts could improve oversight. According to CMS officials, the workgroup will be critical to developing additional oversight strategies and a plan for addressing access and quality in MLTSS. However, the workgroup had not yet documented goals or time frames for completing its work.

CMS officials told us that they have several other new efforts underway that could improve both CMS and state oversight of MLTSS programs, though the outcome of these efforts is uncertain. As of February 2020, CMS officials had developed a preliminary work plan outlining a range of efforts, such as analysis of trends in external quality review findings and a new tool for states to submit annual reports, as mentioned earlier.⁴³ At the time, CMS's planned efforts were largely in the early stages of development, with details yet to be finalized, and were largely focused on managed care programs generally rather than MLTSS programs specifically.

In June 2020, CMS revised the work plan in light of the agency's workload related to Coronavirus Disease 2019 to focus on a shorter list of

⁴²See [GAO-14-704G](#).

⁴³CMS planned to have one of its contractors annually review the external quality review reports that states submit to identify areas for improvement for individual states and nationwide trends.

efforts in the near term. As CMS's planned efforts are still being developed, it is uncertain whether they will ultimately address CMS's information gaps and improve oversight of MLTSS programs. Examples of CMS's planned efforts as of June 2020 included the following:

- **Future appeals and grievance data collection.** CMS plans to develop a standard set of appeals and grievance data to collect from states during the first 6 months of new managed care programs. CMS planned to pilot this approach in September 2020.⁴⁴
- **Potential MLTSS toolkit for states.** CMS planned to develop a toolkit to provide technical assistance to states to improve state oversight and monitoring of MLTSS programs. As of June 2020, CMS had no timeline for beginning this work.⁴⁵

CMS Assesses State Compliance with Contract Requirements and is Exploring Changes to its Contract Review Process

CMS officials told us they have assessed whether states' contracts with MCOs comply with requirements—that is, whether the contracts include provisions required by the 2016 final rule. As of late February and early March 2020, CMS officials said three states had contracts that did not comply with certain requirements pertaining to access and quality of care, nearly 3 years after a number of the requirements took effect.⁴⁶ These

⁴⁴In comments provided in October 2020 on a draft of this report, HHS indicated that these data would be collected during the first year of new managed care programs and that CMS would pilot the approach in 2021.

⁴⁵In comments provided in October 2020 on a draft of this report, HHS indicated that oversight toolkits being developed for states, including on such potential topics as leading practices from states on MLTSS, were planned for 2021.

⁴⁶We asked CMS officials about their assessment of state contracts' compliance with selected requirements within six broad areas: (1) authorization of services, (2) assessment and treatment planning for LTSS, (3) quality of care, (4) provider network adequacy, (5) appeals and grievances, and (6) MCO member advisory committees' LTSS beneficiary representation.

states were California and New York—which together serve more than a third of beneficiaries using MLTSS nationally—and Idaho.⁴⁷ For example:

- **California.** The state had contracts that did not comply with requirements regarding appeals and grievances, LTSS assessments and treatment plans, quality of care, and other areas. According to CMS officials, the state submitted revised contract documentation to address certain contracts' noncompliance in those areas, and CMS approved those revised contracts in March 2020. CMS officials said that other contracts were still noncompliant as of early September 2020 and the state planned to submit contract documentation to CMS to address that noncompliance.
- **New York.** CMS officials told us they became aware in October 2019 that New York's MLTSS contracts did not require MCOs to have a member advisory committee that included LTSS beneficiary representatives, and that they were working with the state to identify options for correcting this omission as soon as possible. The contracts were also noncompliant with two appeals and grievances requirements.⁴⁸ As of August 2020, the state's contracts had become compliant with the appeals and grievances requirements and the state had submitted contract documentation to correct noncompliance with the member advisory committee requirement; CMS officials were reviewing that documentation."

Moving forward, CMS is exploring streamlining its Medicaid managed care contract reviews by using an expedited review process that focuses on requirements the agency deems high risk. To test this approach, CMS began piloting this new process in February 2020. Under the pilot, CMS will review MLTSS contracts—or the MLTSS-specific portion of contracts that also provide non-MLTSS services—for compliance with selected requirements, such as certain care management requirements. For other requirements, CMS will rely on state officials' attestation that the contracts were compliant. (See fig. 7.) CMS officials told us the pilot focuses on

⁴⁷According to CMS, Idaho had contracts that were not compliant with a few appeals and grievance requirements. In September 2020, CMS officials said the contracts were still noncompliant and that the state expected to submit a contract amendment by November 30, 2020.

⁴⁸Specifically, according to CMS officials, New York's contracts were noncompliant with two appeals and grievances requirements that the MCO (1) provide beneficiaries with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments; and (2) inform beneficiaries sufficiently in advance of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution.

conducting expedited reviews for lower-risk contracts. In particular, contracts will be excluded from the pilot if they pertain to a new managed care program, a new MCO joining an existing program, or a new population or benefit being added to an existing program that is considered complex or high risk.

Figure 7: Overview of Changes Being Tested by the Centers for Medicare & Medicaid Services (CMS) for Reviews of Managed Care Contracts' Compliance with Long-Term Services and Supports (LTSS) Requirements

<p>CMS would keep checking contracts' compliance with some LTSS requirements, such as:</p>	<p>CMS might stop checking compliance and rely on state attestation for other LTSS requirements, such as:</p>	<p>State attestation excerpt</p> <p><i>“Based on my best information, knowledge, and belief, the information provided by the state in this document is accurate, complete, and true.</i></p> <p><i>The contract complies with all applicable statutory and regulatory requirements including, but not limited to, those contained in Title 42, Part 438 of the Code of Federal Regulations.”</i></p>
<p>Assessments to Identify Special Conditions</p> <p>Managed care organizations (MCO) must assess each enrollee needing LTSS to identify any ongoing special conditions that require a course of treatment or regular care monitoring</p>	<p>Expertise Needed to Deny or Reduce Services</p> <p>A decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by someone with appropriate expertise in the enrollee's needs</p>	
<p>Coordinator Qualifications for Those Assessments</p> <p>When assessing LTSS enrollees for special conditions, MCOs must use appropriate providers or individuals meeting LTSS service coordination requirements of the state</p>	<p>Assessing Quality and Appropriateness of LTSS Care</p> <p>MCO quality programs must assess quality and appropriateness of care, including (a) an assessment of care between care settings, and (b) a comparison of services and supports received with those in the enrollee's treatment/service plan</p>	
<p>MCO Treatment/Service Plans</p> <p>Must be developed by someone who meets LTSS service coordination requirements, with enrollee participation and consultation with the enrollee's providers</p> <p>Must be developed by a person trained in person-centered planning</p> <p>Must be reviewed and revised upon reassessment of functional need, at least every year, or when enrollee circumstances or needs change significantly, or at the enrollee's request</p>	<p>Efforts to Address Critical Incidents</p> <p>MCOs must participate in state efforts to prevent, detect, and remedy critical incidents</p> <p>Advisory Committee with LTSS Representation</p> <p>MCOs must have a member advisory committee that includes a reasonably representative sample of LTSS enrollees or others representing them</p>	

Source: GAO analysis of CMS information. | GAO-21-49

Text of Figure 7: Overview of Changes Being Tested by the Centers for Medicare & Medicaid Services (CMS) for Reviews of Managed Care Contracts' Compliance with Long-Term Services and Supports (LTSS) Requirements

CMS would keep checking contracts' compliance with some LTSS requirements, such as:

- Assessments to Identify Special Conditions
 - Managed care organizations (MCO) must assess each enrollee needing LTSS to identify any ongoing special conditions that require a course of treatment or regular care monitoring
- Coordinator Qualifications for Those Assessments
 - When assessing LTSS enrollees for special conditions, MCOs must use appropriate providers or individuals meeting LTSS service coordination requirements of the state
- MCO Treatment/Service Plans
 - Must be developed by someone who meets LTSS service coordination requirements, with enrollee participation and consultation with the enrollee's providers
- Must be developed by a person trained in person-centered planning
 - Must be reviewed and revised upon reassessment of functional need, at least every year, or when enrollee circumstances or needs change significantly, or at the enrollee's request

CMS might stop checking compliance and rely on state attestation for other LTSS requirements, such as:

- Expertise Needed to Deny or Reduce Services
 - A decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by someone with appropriate expertise in the enrollee's needs
- Assessing Quality and Appropriateness of LTSS Care
 - MCO quality programs must assess quality and appropriateness of care, including (a) an assessment of care between care settings, and (b) a comparison of services and supports received with those in the enrollee's treatment/service plan
- Efforts to Address Critical Incidents

- MCOs must participate in state efforts to prevent, detect, and remedy critical incidents
- Advisory Committee with LTSS Representation
 - MCOs must have a member advisory committee that includes a reasonably representative sample of LTSS enrollees or others representing them

CMS officials told us they plan to evaluate the pilot and use their findings to determine whether to implement expedited contract reviews more broadly. For example, CMS will complete a quality check in which CMS staff review a sample of contracts using both the expedited review tool and the regular comprehensive review tool. The results of that quality check will help CMS assess the viability of expedited reviews. CMS's use of quality checks is an important control, particularly given that in early 2020 some states were still noncompliant with several of the requirements for which CMS might rely on attestation. This included the requirement that MCOs have member advisory committees with LTSS representation, for example. Without such controls, the approach being piloted could increase the risk of noncompliance.

Conclusions

Oversight of LTSS is a challenging responsibility for states and the federal government, regardless of the delivery model. However, managed care presents unique complexities. Reviews completed by our selected states suggest that there may be widespread issues with MCO care management for beneficiaries of LTSS, some of which come with costs to the beneficiary in terms of injury, abuse, and neglect—as well as financial costs associated with increased treatment needs. This was true not only in states with relatively new MLTSS programs, but also in states that have been operating managed care programs for many years. Moreover, there is evidence to suggest that states were not always taking the actions needed to resolve the problems identified.

CMS could be a partner in helping states hold MCOs accountable and improve oversight approaches, but the agency has done little to advance its MLTSS oversight efforts since issuing new managed care rules in 2016. The agency has not taken steps to assess the effectiveness of states' implementation of monitoring and beneficiary protection provisions, potentially leaving the agency unaware of significant quality and access issues. This appeared to be a reflection of the larger issue

that CMS lacks an oversight strategy specific to MLTSS and a complete picture of the access and quality problems in MLTSS programs. CMS's planned oversight changes are tentative and conceptual at this point. Absent more specific actions, CMS cannot help enhance state and MCO accountability, leaving beneficiaries at continued risk of not receiving needed care—despite billions of dollars of spending.

Recommendations for Executive Action

We are making the following two recommendations to CMS:

1. The Administrator of CMS should develop and implement a national strategy for monitoring MLTSS programs and ensuring that states and MCOs resolve identified problems. Among other things, this strategy should address state implementation of beneficiary protection and monitoring requirements. (Recommendation 1)
2. The Administrator of CMS should assess the nature and prevalence of MLTSS access and quality problems across states. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of the report to HHS for comment and its comments are reproduced in appendix II. HHS did not concur with our recommendations.

In its comments, HHS described a variety of activities CMS has recently initiated to improve monitoring and oversight for managed care and LTSS generally, many of which we describe in this report. For example, CMS is in the process of developing a template for annual state reporting on managed care programs, as required in the 2016 managed care rule. The agency also reported plans to pilot and publish new managed care monitoring and oversight tools for states, and recently convened a cross-cutting workgroup to assess existing MLTSS oversight activities to determine where additional improvements could be made. It is positive that CMS is taking steps to improve monitoring and oversight. However, as we describe in our report, many of these efforts are in the early planning stages and HHS did not indicate how these efforts will address the oversight problems with MLTSS that we identified in this report.

Regarding our first recommendation to develop and implement a national strategy for monitoring MLTSS programs and ensuring that states and MCOs resolve identified problems, HHS disagreed. HHS commented that such a step was not necessary, because CMS has strategies to enhance oversight in LTSS and managed care more generally. Our work indicates that relying primarily on a general approach to oversight has not been effective and has allowed significant problems with quality and access in MLTSS to go undetected by CMS and persist for years. Moreover, it is not clear that such strategies will address risks unique to MLTSS, where MCOs are delegated the responsibility for care planning, authorizing services, and monitoring safety and quality of care for beneficiaries who have complex needs and can be vulnerable to injury, abuse, and neglect. The work group that CMS recently convened is promising, but as noted in the report, the goals and time frames for the work group are unclear. We maintain that having a national oversight strategy specifically for MLTSS could provide direction to CMS's broader efforts and ensure that the agency is able to detect and address quality and access problems experienced by MLTSS beneficiaries.

Regarding our second recommendation to assess the nature and prevalence of quality and access problems in MLTSS across states, HHS disagreed. HHS said CMS is planning to do such an assessment in the broader context of managed care and LTSS generally. HHS also reiterated having a number of new tools under development that would provide information on the prevalence and nature of problems. However, as HHS notes, the tools it identified are still in development, whereas our work shows that there is in-depth information currently available from states about existing quality and access problems in MLTSS programs. It is unclear what information CMS will be collecting and whether that information would provide a comprehensive picture about the nature and prevalence of these problems in MLTSS. We maintain that assessing the prevalence and nature of quality and access problems in MLTSS specifically would provide CMS with the information necessary to effectively target its oversight.

HHS also provided us with technical comments, which we incorporated as appropriate.

As agreed with your office, 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 appropriate congressional committees and the Secretary of Health and Human

Services. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or YocomC@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 who made key contributions to this report are listed in appendix III.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Carolyn L. Yocom". The signature is fluid and cursive, with a long horizontal stroke at the end.

Carolyn L. Yocom
Director, Health Care

Appendix I: Characteristics of Selected State Managed Long-Term Services and Supports Programs

Our six selected states—Arizona, Florida, Iowa, New York, Texas, and Virginia—have Medicaid managed long-term services and supports (MLTSS) programs that varied across a number of characteristics, such as program start year, enrollment, and cost. For example, the MLTSS programs in Iowa and Virginia both began within the last 5 years, while the MLTSS programs in Arizona and Texas began over 20 years ago. (See table 4.) In addition, in 2019, total capitated payments to managed care organizations for MLTSS, as reported by each of the six states, ranged from \$1.9 billion in Iowa to \$13.6 billion in New York.

Table 4: Characteristics of Medicaid Managed Long-Term Services and Supports (MLTSS) Programs in Selected States, 2019

State	Program age ^a	Enrollment	Types of beneficiaries receiving MLTSS				Number of MCOs under contract	Capitated payments for MLTSS enrollees (dollars in millions)
			Seniors	Adults with physical disabilities	Adults with developmental disabilities	Children with disabilities		
Arizona	1989	67,785	Yes	Yes	Yes	Yes	4 MCOs ^b	2,888
Florida	2013	116,398	Yes	Yes	-	-	8 MCOs	4,475
Iowa	2016	37,817	Yes	Yes	Yes	Yes	2 MCOs	1,953
New York	1998	272,212	Yes	Yes	Yes	-	27 MCOs	13,664
Texas	1998	709,209 ^c	Yes	Yes	-	Yes	12 MCOs	12,881
Virginia	2017	52,795	Yes	Yes	Yes	Yes	6 MCOs	2,695

Source: GAO summary of state information. | GAO-21-49

Notes: Enrollment data are as of December 2019 for Florida, Iowa, Texas, New York, and Virginia. For Arizona, enrollment data is as of September 2019. Capitated payment data are for state fiscal year 2019 for all states. The number of managed care organizations (MCO) under contract are for state fiscal year 2019 for Arizona, Florida, Iowa, Texas, and Virginia. The number of MCOs under contract for New York is as of December 2019.

^aIn states with multiple MLTSS programs, this column reflects the age of the oldest program.

^bArizona has an MCO that is part of a state agency. This MCO is included in the total.

^cEnrollment for Texas includes beneficiaries that do not require a nursing facility level of care, but who receive community based care.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

October 26, 2020

Carolyn Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICAID LONG-TERM SERVICES AND SUPPORTS: Access and Quality Problems in Managed Care Demand Improved Oversight" (Job code 103872/ GAO-21-49).

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

Sincerely,

Sarah C.
Arbes -S

Digitally signed by
Sarah C. Arbes -S
Date: 2020.10.26
21:52:17 -04'00'

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

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

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID LONG TERM SERVICES AND SUPPORTS:
ACCESS AND QUALITY PROBLEMS IN MANAGED CARE DEMAND IMPROVED
OVERSIGHT (GAO-21-49)**

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on the GAO's draft report on Medicaid managed care long-term services and supports (MLTSS) programs. HHS and the Centers for Medicare & Medicaid Services (CMS) takes seriously its efforts to oversee access and quality in states' MLTSS programs.

Recognizing that the assurance of quality long-term services and supports is equally important across service delivery mechanisms, CMS is initiating activities that will improve the provision of Medicaid home and community-based services (HCBS) in both managed care and fee-for-service. One notable example is the development of a recommended set of performance measures that will assist states, managed care plans, and other stakeholders to better evaluate how the HCBS made available to Medicaid beneficiaries are facilitating independence and community integration. Another key effort CMS is undertaking is the implementation of a multi-faceted technical assistance framework to reduce disparities within and across states on how critical incidents in HCBS programs are identified, reported and investigated, and how effective remediation strategies can reduce the recurrence of these incidents.

In addition, CMS has taken several concrete steps to enhance Medicaid managed care oversight generally. In fall 2019, the Center for Medicaid and CHIP Services (CMCS) within CMS underwent a reorganization to better align the agency's mission-critical work with a more efficient and effective organizational structure. One of the overarching goals with the reorganization was to execute a renewed focus and dedicated strategy for managed care monitoring and oversight, including MLTSS oversight, in a more structured way. Specifically, the reorganization included creating a new division focused solely on managed care operations, which includes oversight of state managed care programs from pre-approval through post-approval status. To that end, CMS strongly disagrees with the GAO's characterization that HHS lacks a national strategy for oversight, as CMS has communicated the overarching goals and strategy for refining and enhancing our monitoring and oversight work with states. As part of this strategy, CMS described to the GAO the current process of identifying and cataloging current oversight and monitoring activities to determine where additional improvements could be made to continually enhance the oversight of MLTSS programs, as well as train applicable team members on monitoring and oversight protocols in a more consistent and cohesive manner. As described to the GAO, CMS has already launched a cross-cutting workgroup to advance this work across CMCS. We believe this approach will help infuse our monitoring and oversight efforts into the daily work of our staff.

As the GAO notes in their report, states can implement MLTSS using an array of managed care statutory authorities under the Social Security Act (the Act), including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115(a) demonstration. States are increasingly incorporating populations and services that have long been excluded from capitated managed care arrangements into these models of care. To that end, states have the primary responsibility to conduct monitoring and oversight of their managed care plans. As the direct administrators of their Medicaid program, states have an obligation to ensure that their managed care plans are performing in accordance with state and federal requirements, as well as ensuring that managed care plans are providing timely access to

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

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID LONG TERM SERVICES AND SUPPORTS: ACCESS AND QUALITY PROBLEMS IN MANAGED CARE DEMAND IMPROVED OVERSIGHT (GAO-21-49)

high-quality healthcare in accordance with their contractual requirements. It is CMS' responsibility to hold states accountable for meeting these standards. This is one of the primary reasons that CMS is investing in the development of new tools to strengthen states' ongoing efforts to oversee their managed care programs. CMS described for the GAO plans to pilot and publish managed care monitoring and oversight tools that will help states fulfill their obligation to hold managed care plans accountable for the healthcare provided to Medicaid beneficiaries. While development of these tools was delayed as a result of the HHS efforts to combat the 2019 Novel Coronavirus Disease public health emergency, work has begun and they remain a priority for CMS.

The new oversight tools will help states and CMS assess the nature and prevalence of access and quality issues. For example, one of the tools recently developed and soon to be piloted will collect a standard set of appeals and grievances data from states and managed care plans during the first year of new managed care programs. The standard data set collected by the appeals and grievances tool will provide valuable data to help states and CMS better assess overarching trends in managed care programs, including the ability to monitor trends in the types of covered benefits commonly involved in appeals and grievances. States and CMS can use this information to identify systemic barriers to beneficiaries' access to services, as well as the potential need for states or CMS to intervene with managed care plans to resolve outstanding access or quality issues. We are planning to pilot the appeals and grievances tool in 2021, with a publication goal by the end of 2021.

Further, as CMS described to the GAO, we will continue our development of a standardized template to help states comply with submitting an annual program report as required in 42 C.F.R. § 438.66(e). These reports address 10 specific areas of the managed care program's operations as outlined in the regulation at 42 C.F.R. § 438.66(e)(2) and require, as applicable, that such reports include information on, and an assessment of, the operation of the managed care program, including MLTSS-specific information. CMS continues to work on a standard template for these reports to facilitate gathering complete and consistent information on the performance of each managed care program, including MLTSS-specific information, which CMS intends to use to assess the nature and prevalence of MLTSS access and quality issues. CMS is currently in the process of developing the tool, which will be piloted in early 2021 with select states, with a publication goal by the end of 2021. In addition, we are currently developing new technical assistance toolkits planned for 2021, described later in this response.

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, CMS has provided guidance to states on the implementation of their MLTSS programs. This includes guidance issued by CMS on May 20, 2013,¹ that provided ten key principles inherent in a strong MLTSS program, including a focus

¹ Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs (May 2013) (available at: <https://www.medicaid.gov/Medicaid/downloads/1115-and-1915b-mltss-guidance.pdf>).

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID LONG TERM SERVICES AND SUPPORTS: ACCESS AND QUALITY PROBLEMS IN MANAGED CARE DEMAND IMPROVED OVERSIGHT (GAO-21-49)

on person-centered processes to ensure active participation by the beneficiary, or their designee, in the service planning and delivery process. CMS believes these guiding principles, while not exhaustive and subject to further refinement as states and CMS gain further experience, are critical to the successful implementation and operation of state MLTSS programs that support greater integration of care for beneficiaries with the most significant needs. On May 6, 2016, CMS finalized a rule for Medicaid managed care entitled, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule (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 requires managed care plans to participate in efforts by the state to prevent, detect, and report critical incidents.

To oversee access and quality in state MLTSS programs, CMS performs a number of continual monitoring efforts. These include mechanisms such as routine interactions with states and managed care plans, review and approval of managed care contracts, capitation rates, waiver, state plan, and demonstration applications and renewals, direct episodic stakeholder input, external quality reviews, as well as review and receipt of specific reporting requirements mandated by sections 1915(b), 1915(c), and 1115(a) of the Act and by the managed care regulations in 42 C.F.R. Part 438. In its report, the GAO provides examples of when CMS became aware of access and quality problems via beneficiary complaints and media reports. However, CMS believes that it is appropriate to monitor all aspects of a managed care program, which include both routine monitoring and oversight of state programs and environmental scanning of beneficiary complaints, provider complaints, and media reports. Environmental scanning is part of prudent program management. Information gathered from these various sources is investigated as needed and used to inform CMS actions, such as contract reviews and future waiver and demonstration applications and renewals. Even with these actions, CMS is planning to do more, including scheduling additional reviews of managed care programs post approval to identify systematic issues earlier.

As noted earlier, CMS has recently convened a cross-cutting workgroup to assess existing MLTSS oversight tools to determine where additional efforts are needed, if necessary. The agency is working to develop new toolkits for release in 2021 on the following potential topics: (1) MLTSS toolkit describing leading practices from states; (2) Behavioral health access toolkit; (3) Managing plan transitions toolkit, including enrollee notices and state responsibilities when plans enter and exit markets; (4) Provider screening and enrollment toolkit; (5) Quality strategy toolkit; and (6) Program integrity toolkit for managed care. CMS is also working on a plan to update and modernize our systems to support improved monitoring and oversight activities. These efforts include enhanced automation of current work streams, including contract and rate review, and the electronic collection of various reporting requirements. CMS is also exploring ways to facilitate greater real-time monitoring and oversight through better data collection and coordination as part of external quality reviews. As part of this workgroup, CMS is also exploring further rulemaking to require additional state and managed care plan reporting to improve CMS' oversight and monitoring efforts.

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

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID LONG TERM SERVICES AND SUPPORTS: ACCESS AND QUALITY PROBLEMS IN MANAGED CARE DEMAND IMPROVED OVERSIGHT (GAO-21-49)

Finally, to support state program oversight and evaluation efforts, CMS has produced and published eight measures² that states may elect to use to evaluate their MLTSS plans' performance. The measures address plan performance of comprehensive assessments and care plans, falls assessment and prevention, as well as measuring institutional admissions, discharges, and lengths of stay.

CMS believes that the use of multiple oversight mechanisms provides a timely and comprehensive view of overall program function and effectiveness and is generally more reflective of a state's performance. CMS is committed to improving MLTSS oversight efforts at the federal level; these efforts are part of a larger strategy to improve and enhance monitoring and oversight of Medicaid managed care programs and to improve the quality of LTSS service provision in all delivery systems.

Recommendation

The Administrator of CMS should develop and implement a national strategy for monitoring MLTSS programs and ensuring that states and MCOs resolve identified problems. Among other things, this strategy should address state implementation of beneficiary protection and monitoring requirements.

CMS Response

CMS does not concur with this recommendation as we believe it is not necessary. CMS began laying the groundwork for the development of a national strategy prior to the beginning of the GAO's work and CMS continues to make progress toward this goal. As noted in the GAO report, CMS convened a workgroup to assess existing MLTSS oversight tools to determine where additional efforts are needed, and is using this workgroup to further develop and ultimately implement our strategy for monitoring state MLTSS programs. This MLTSS strategy is part of a larger strategy that the agency is currently pursuing to improve and enhance our monitoring and oversight efforts in Medicaid managed care and to improve the quality of LTSS service provision in all delivery systems. As noted earlier, CMS has a number of monitoring and oversight tools in various stages of development, including:

- A standard set of appeals and grievances data from states and managed care plans during the first year of new managed care programs: The tool is currently in development, and we are planning to pilot the tool in 2021.
- An annual program report from all states with managed care programs: The tool is being developed and will be piloted in early 2021 with select states, with a publication goal by the end of 2021.
- New toolkits in 2021 on the following potential topics: (1) MLTSS toolkit describing leading practices from states; (2) Behavioral health access toolkit; (3) Managing plan transitions toolkit, including enrollee notices and state responsibilities when plans enter and exit markets; (4) Provider screening and enrollment toolkit; (5) Quality strategy toolkit; and (6) Program integrity toolkit for managed care.

Recommendation

² Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual (May 2019) (available at: <https://www.medicaid.gov/media/3396>)

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

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID LONG TERM SERVICES AND SUPPORTS:
ACCESS AND QUALITY PROBLEMS IN MANAGED CARE DEMAND IMPROVED
OVERSIGHT (GAO-21-49)**

The Administrator of CMS should assess the nature and prevalence of MLTSS access and quality problems across states.

CMS Response

CMS does not concur with this recommendation as it does not sufficiently capture the scope of this work. We are in the process of developing a plan to further assess the nature and prevalence of MLTSS access and quality issues and have a number of important activities planned. However, ensuring access to quality services are important regardless of delivery system. As noted in the previous response, CMS is pursuing enhanced MLTSS oversight as part of a larger strategy to improve and enhance overall Medicaid managed care oversight and a strategy to improve the quality of LTSS service provision under both FFS and managed care delivery systems. To that end, CMS will continue our current plans to develop and finalize the tools identified above to improve MLTSS oversight, including finalizing the appeals and grievances data tool as described above. The standard data set of the appeals and grievances tool will include data on critical incidents. CMS will also continue our development of a standardized template to help states comply with submitting the annual program report as required in 42 C.F.R. § 438.66(e). These annual reports, submitted by states to CMS, will include information on and an assessment of the operation of each state's managed care program, including MLTSS-specific information, which CMS will use to assess the nature and prevalence of MLTSS access and quality issues. In addition, we have a number of toolkits planned for 2021, as described previously, including an MLTSS toolkit describing leading practices from states in the area of access and quality.

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

October 26, 2020

Carolyn Yocom Director, Health Care

U.S. Government Accountability Office 441 G Street NW

Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICAID LONG-TERM SERVICES AND SUPPORTS: Access and Quality Problems in Managed Care Demand Improved Oversight" (Job code 103872/ GAO-21-49).

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

Sincerely,

Sarah C. Arbes

Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID LONG TERM SERVICES AND SUPPORTS: ACCESS AND QUALITY PROBLEMS IN MANAGED CARE DEMAND IMPROVED OVERSIGHT (GAO-21-49)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on the GAO's draft report on Medicaid managed care long-term services and supports (MLTSS) programs. HHS and the Centers for Medicare & Medicaid

Services (CMS) takes seriously its efforts to oversee access and quality in states' MLTSS programs.

Recognizing that the assurance of quality long-term services and supports is equally important across service delivery mechanisms, CMS is initiating activities that will improve the provision of Medicaid home and community-based services (HCBS) in both managed care and fee-for-service. One notable example is the development of a recommended set of performance measures that will assist states, managed care plans, and other stakeholders to better evaluate how the HCBS made available to Medicaid beneficiaries are facilitating independence and community integration. Another key effort CMS is undertaking is the implementation of a multi-faceted technical assistance framework to reduce disparities within and across states on how critical incidents in HCBS programs are identified, reported and investigated, and how effective remediation strategies can reduce the recurrence of these incidents.

In addition, CMS has taken several concrete steps to enhance Medicaid managed care oversight generally. In fall 2019, the Center for Medicaid and CHIP Services (CMCS) within CMS underwent a reorganization to better align the agency's mission-critical work with a more efficient and effective organizational structure. One of the overarching goals with the reorganization was to execute a renewed focus and dedicated strategy for managed care monitoring and oversight, including MLTSS oversight, in a more structured way. Specifically, the reorganization included creating a new division focused solely on managed care operations, which includes oversight of state managed care programs from pre-approval through post-approval status. To that end, CMS strongly disagrees with the GAO's characterization that HHS lacks a national strategy for oversight, as CMS has communicated the overarching goals and strategy for refining and enhancing our monitoring and oversight work with states. As part of this strategy, CMS described to the GAO the current process of identifying and cataloging current oversight and monitoring activities to determine where additional improvements could be made to continually enhance the oversight of MLTSS programs, as well as train applicable team members on monitoring and oversight protocols in a more consistent and cohesive manner. As described to the GAO, CMS has already launched a cross-cutting workgroup to advance this work across CMCS. We believe this approach will help infuse our monitoring and oversight efforts into the daily work of our staff.

As the GAO notes in their report, states can implement MLTSS using an array of managed care statutory authorities under the Social Security Act (the Act), including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115(a) demonstration. States are increasingly incorporating populations and services that have long been excluded from capitated managed care arrangements into these models of care. To that end, states have the primary responsibility to conduct monitoring and oversight of their managed care

plans. As the direct administrators of their Medicaid program, states have an obligation to ensure that their managed care plans are performing in accordance with state and federal requirements, as well as ensuring that managed care plans are providing timely access to high-quality healthcare in accordance with their contractual requirements. It is CMS' responsibility to hold states accountable for meeting these standards. This is one of the primary reasons that CMS is investing in the development of new tools to strengthen states' ongoing efforts to oversee their managed care programs. CMS described for the GAO plans to pilot and publish managed care monitoring and oversight tools that will help states fulfill their obligation to hold managed care plans accountable for the healthcare provided to Medicaid beneficiaries. While development of these tools was delayed as a result of the HHS efforts to combat the 2019 Novel Coronavirus Disease public health emergency, work has begun and they remain a priority for CMS.

The new oversight tools will help states and CMS assess the nature and prevalence of access and quality issues. For example, one of the tools recently developed and soon to be piloted will collect a standard set of appeals and grievances data from states and managed care plans during the first year of new managed care programs. The standard data set collected by the appeals and grievances tool will provide valuable data to help states and CMS better assess overarching trends in managed care programs, including the ability to monitor trends in the types of covered benefits commonly involved in appeals and grievances. States and CMS can use this information to identify systemic barriers to beneficiaries' access to services, as well as the potential need for states or CMS to intervene with managed care plans to resolve outstanding access or quality issues. We are planning to pilot the appeals and grievances tool in 2021, with a publication goal by the end of 2021.

Further, as CMS described to the GAO, we will continue our development of a standardized template to help states comply with submitting an annual program report as required in 42 C.F.R. § 438.66(e). These reports address 10 specific areas of the managed care program's operations as outlined in the regulation at 42 C.F.R. § 438.66(e)(2) and require, as applicable, that such reports include information on, and an assessment of, the operation of the managed care program, including MLTSS-specific information. CMS continues to work on a standard template for these reports to facilitate gathering complete and consistent information on the performance of each managed care program, including MLTSS-specific information, which CMS intends to use to assess the nature and prevalence of MLTSS access and quality issues. CMS is currently in the process of developing the tool, which will be piloted in early 2021 with select states, with a publication goal by the end of 2021. In addition, we are currently developing new technical assistance toolkits planned for 2021, described later in this response.

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, CMS has provided guidance to states on the implementation of their MLTSS programs. This includes guidance issued by CMS on May 20, 2013,¹ 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 their designee, in the service planning and delivery process. CMS believes these guiding principles, while not exhaustive and subject to further refinement as states and CMS gain further experience, are critical to the successful implementation and operation of state MLTSS programs that support greater integration of care for beneficiaries with the most significant needs. On May 6, 2016, CMS finalized a rule for Medicaid managed care entitled, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule (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 requires managed care plans to participate in efforts by the state to prevent, detect, and report critical incidents.

To oversee access and quality in state MLTSS programs, CMS performs a number of continual monitoring efforts. These include mechanisms such as routine interactions with states and managed care plans, review and approval of managed care contracts, capitation rates, waiver, state plan, and demonstration applications and renewals, direct episodic stakeholder input, external quality reviews, as well as review and receipt of specific reporting requirements mandated by sections 1915(b), 1915(c), and 1115(a) of the Act and by the managed care regulations in 42 C.F.R. Part 438. In its report, the GAO provides examples of when CMS became aware of access and quality problems via beneficiary complaints and media reports. However, CMS believes that it is appropriate to monitor all aspects of a managed care program, which include both routine monitoring and oversight of state programs and environmental scanning of beneficiary complaints, provider complaints, and media reports. Environmental scanning is part of prudent program management. Information gathered from these various sources is investigated as needed and used to inform CMS actions, such as contract reviews and future waiver and demonstration applications and renewals. Even with these actions, CMS is planning

¹ Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs (May 2013) (available at: <https://www.medicaid.gov/Medicaid/downloads/1115-and-1915b-mltss-guidance.pdf>).

to do more, including scheduling additional reviews of managed care programs post approval to identify systematic issues earlier.

As noted earlier, CMS has recently convened a cross-cutting workgroup to assess existing MLTSS oversight tools to determine where additional efforts are needed, if necessary. The agency is working to develop new toolkits for release in 2021 on the following potential topics: (1) MLTSS toolkit describing leading practices from states; (2) Behavioral health access toolkit; (3) Managing plan transitions toolkit, including enrollee notices and state responsibilities when plans enter and exit markets; (4) Provider screening and enrollment toolkit; (5) Quality strategy toolkit; and (6) Program integrity toolkit for managed care. CMS is also working on a plan to update and modernize our systems to support improved monitoring and oversight activities. These efforts include enhanced automation of current work streams, including contract and rate review, and the electronic collection of various reporting requirements. CMS is also exploring ways to facilitate greater real-time monitoring and oversight through better data collection and coordination as part of external quality reviews. As part of this workgroup, CMS is also exploring further rulemaking to require additional state and managed care plan reporting to improve CMS' oversight and monitoring efforts.

Finally, to support state program oversight and evaluation efforts, CMS has produced and published eight measures² that states may elect to use to evaluate their MLTSS plans' performance. The measures address plan performance of comprehensive assessments and care plans, falls assessment and prevention, as well as measuring institutional admissions, discharges, and lengths of stay.

CMS believes that the use of multiple oversight mechanisms provides a timely and comprehensive view of overall program function and effectiveness and is generally more reflective of a state's performance. CMS is committed to improving MLTSS oversight efforts at the federal level; these efforts are part of a larger strategy to improve and enhance monitoring and oversight of Medicaid managed care programs and to improve the quality of LTSS service provision in all delivery systems.

Recommendation

The Administrator of CMS should develop and implement a national strategy for monitoring MLTSS programs and ensuring that states and MCOs resolve identified

² Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual (May 2019) (available at: <https://www.medicaid.gov/media/3396>)

problems. Among other things, this strategy should address state implementation of beneficiary protection and monitoring requirements.

CMS Response

CMS does not concur with this recommendation as we believe it is not necessary. CMS began laying the groundwork for the development of a national strategy prior to the beginning of the GAO's work and CMS continues to make progress toward this goal. As noted in the GAO report, CMS convened a workgroup to assess existing MLTSS oversight tools to determine where additional efforts are needed, and is using this workgroup to further develop and ultimately implement our strategy for monitoring state MLTSS programs. This MLTSS strategy is part of a larger strategy that the agency is currently pursuing to improve and enhance our monitoring and oversight efforts in Medicaid managed care and to improve the quality of LTSS service provision in all delivery systems. As noted earlier, CMS has a number of monitoring and oversight tools in various stages of development, including:

- A standard set of appeals and grievances data from states and managed care plans during the first year of new managed care programs: The tool is currently in development, and we are planning to pilot the tool in 2021.
- An annual program report from all states with managed care programs: The tool is being developed and will be piloted in early 2021 with select states, with a publication goal by the end of 2021.
- New toolkits in 2021 on the following potential topics: (1) MLTSS toolkit describing leading practices from states; (2) Behavioral health access toolkit; (3) Managing plan transitions toolkit, including enrollee notices and state responsibilities when plans enter and exit markets; (4) Provider screening and enrollment toolkit; (5) Quality strategy toolkit; and (6) Program integrity toolkit for managed care.

Recommendation

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CMS Response

CMS does not concur with this recommendation as it does not sufficiently capture the scope of this work. We are in the process of developing a plan to further assess the nature and prevalence of MLTSS access and quality issues and have a number of important activities planned. However, ensuring access to quality services are important regardless of delivery system. As noted in the previous response, CMS is pursuing enhanced MLTSS oversight as part of a larger strategy to improve and enhance overall Medicaid managed care oversight and a strategy to improve the

quality of LTSS service provision under both FFS and managed care delivery systems. To that end, CMS will continue our current plans to develop and finalize the tools identified above to improve MLTSS oversight, including finalizing the appeals and grievances data tool as described above. The standard data set of the appeals and grievances tool will include data on critical incidents. CMS will also continue our development of a standardized template to help states comply with submitting the annual program report as required in 42 C.F.R. § 438.66(e). These annual reports, submitted by states to CMS, will include information on and an assessment of the operation of each state's managed care program, including MLTSS-specific information, which CMS will use to assess the nature and prevalence of MLTSS access and quality issues. In addition, we have a number of toolkits planned for 2021, as described previously, including an MLTSS toolkit describing leading practices from states in the area of access and quality.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Mary Giffin (Analyst-in-Charge), Robin Burke, Dhara Patel, and Lillian Schultze made key contributions to this report. Also contributing were Drew Long, Diona Martyn, Eric Peterson, Ethiene Salgado-Rodriguez, and Jennifer Whitworth.

Related GAO Reports

Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse. [GAO-19-433](#). Washington, D.C.: June 13, 2019.

Medicaid Home- and Community-Based Services: Selected States' Program Structures and Challenges Providing Services. [GAO-18-628](#). Washington, D.C.: August 30, 2018.

Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed. [GAO-18-179](#). Washington, D.C.: January 5, 2018.

Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services. [GAO-18-103](#). Washington, D.C.: December 14, 2017.

Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs. [GAO-17-632](#). Washington, D.C.: August 14, 2017.

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

Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs. [GAO-17-28](#). Washington, D.C.: November 23, 2016.

Older Adults: Federal Strategy Needed to Help Ensure Efficient and Effective Delivery of Home and Community-Based Services and Supports. [GAO-15-190](#). Washington, D.C.: May 20, 2015.

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