



September 2021

MEDICAID HOME- AND COMMUNITY- BASED SERVICES

Evaluating COVID-19 Response Could Help CMS Prepare for Future Emergencies

Accessible Version

GAO Highlights

Highlights of [GAO-21-104401](#), a report to congressional committees

Why GAO Did This Study

During emergencies, including COVID-19, CMS may approve certain temporary changes to states' Medicaid programs to ensure access to care. These changes are critical to beneficiaries who rely on HCBS to perform daily activities, such as eating, and who may face greater risk of COVID-19.

The CARES Act includes a provision for GAO to report on its ongoing COVID-19 monitoring and oversight efforts. In addition, GAO was asked to examine temporary changes to Medicaid in response to COVID-19. This report (1) describes temporary changes to Medicaid HCBS programs, including selected states' experience in making these changes; and (2) examines CMS's monitoring and evaluation of the effects of those changes.

GAO reviewed documentation of temporary changes approved by CMS and relevant CMS policies, procedures, and analyses. GAO also interviewed Medicaid officials from CMS and six states selected based on variation in Medicaid expenditures and geographic region. GAO assessed CMS's monitoring and evaluation activities using CMS's *Pandemic Plan* and federal internal control standards.

What GAO Recommends

GAO is making two recommendations to CMS to (1) develop procedures to monitor temporary changes to HCBS programs during public health emergencies; and (2) evaluate the temporary changes after the COVID-19 emergency and address opportunities for improvement. The Department of Health and Human Services concurred with GAO's recommendations.

View [GAO-21-104401](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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Evaluating COVID-19 Response Could Help CMS Prepare for Future Emergencies

What GAO Found

COVID-19 presented risks to Medicaid home- and community-based services (HCBS) programs, where providers help beneficiaries with daily activities, such as bathing, dressing, and eating. To maintain access to services and prevent disease spread, all states received approval for temporary changes to their HCBS programs from the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services. These changes enabled selected states to limit in-person contact to reduce the spread of the disease, but also led to new challenges to ensuring beneficiary health and welfare.

Examples of Temporary Changes to States' Medicaid Home- and Community-Based Services Due to COVID-19, as of December 2020



Source: GAO analysis of documents from the Centers for Medicare & Medicaid Services. | GAO-21-104401

Text of Examples of Temporary Changes to States' Medicaid Home- and Community-Based Services Due to COVID-19, as of December 2020

- Modified service planning (e.g., conducted over the phone instead of in person): 50 states
- Delayed or suspended provider requirements (e.g., background checks): 48 states
- Increased payments to providers (e.g., for hazard pay): 38 states
- Allowed Service provision in new settings (e.g., outside provider facilities): 49 states

Source: GAO analysis of documents from the Centers for Medicare & Medicaid Services. | GAO-21-104401

CMS focused on supporting states' implementation of temporary changes and conducted limited oversight of the effects of the changes. CMS's *Pandemic Plan* establishes the need for monitoring to make mid-course corrections and conducting evaluations after the pandemic to inform future emergency response.

- **CMS relied on states to monitor during the emergency.** CMS has no procedures for monitoring temporary changes during an emergency. Instead, states had the primary responsibility to monitor the effects of temporary

changes during the COVID-19 emergency, according to CMS officials. CMS provided limited guidance to states on monitoring the changes, and did not request that states share any data, such as COVID-19 infections or deaths, with CMS. Without developing monitoring procedures in advance of future public health emergencies, CMS is unlikely to conduct necessary monitoring.

- **CMS's plan for evaluating after the emergency is unclear.** CMS officials told GAO that they intend to evaluate temporary changes made to HCBS programs, but had not developed plans to do so. Officials said they will continue to review regular state reporting on steps taken to ensure the overall quality of HCBS programs. However, this reporting may not provide useful information for evaluating how temporary changes affected access to HCBS or the prevention of disease spread, and some reports are not due for more than 3 years. Without a full evaluation, CMS may miss opportunities to better prepare for future emergencies.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HCBS	home- and community-based services
HHS	Department of Health and Human Services

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September 8, 2021

Congressional Committees

Deadly public health emergencies, such as the Coronavirus Disease 2019 (COVID-19), present Medicaid home- and community-based services (HCBS) programs with the dual challenge of preventing the spread of disease while maintaining access to care. These programs provide Medicaid beneficiaries who are aged or have disabilities with long-term services and supports, including assistance with daily activities, such as eating, dressing, and bathing. Beneficiaries rely on HCBS to live in their homes and communities rather than in institutional settings, including nursing homes, which have been the site of severe COVID-19 outbreaks.¹ However, delivering HCBS commonly involves close in-person contact between providers and beneficiaries that can cause the spread of infectious disease. Further, HCBS beneficiaries may be particularly vulnerable to these diseases due to age or disability, as occurred with COVID-19.²

Medicaid, a federal-state health financing program for certain low-income and medically needy individuals, provided HCBS to over 3.6 million beneficiaries in fiscal year 2018.³ Medicaid spends more than any other payer—approximately 51 percent of \$393 billion in 2019—in the United

¹See GAO, *COVID-19 in Nursing Homes: Most Homes Had Multiple Outbreaks and Weeks of Sustained Transmission from May 2020 through January 2021*, [GAO-21-367](#) (Washington, D.C.: May 19, 2021). We regularly issue government-wide reports on the federal response to COVID-19. For the latest report, see GAO, *COVID-19: Continued Attention Needed to Enhance Federal Preparedness, Response, Service Delivery, and Program Integrity*, [GAO-21-551](#) (Washington, D.C.: July 19, 2021). Our next government-wide report will be issued in October 2021 and will be available on GAO's website at <https://www.gao.gov/coronavirus>.

²See, for example, Scott D. Landes et al., "COVID-19 Outcomes Among People with Intellectual and Developmental Disability Living in Residential Group Homes in New York State," *Disability and Health Journal* vol. 13, no. 4 (2020): 100969.

³These beneficiaries received at least one non-institutional long-term service or support in fiscal year 2018 under a fee-for-service arrangement, according to the Centers for Medicare & Medicaid Services' Transformed Medicaid Statistical Information System data, as of April 2020. Approximately 2 million of these beneficiaries received HCBS under a waiver program authorized by section 1915(c) of the Social Security Act. See Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book* (December 2020).

States on long-term services and supports, and most of this spending has gone toward HCBS in recent years.⁴

States have considerable flexibility to vary the provision of HCBS.⁵ Nearly all states provide Medicaid HCBS through waivers approved by the Centers for Medicare & Medicaid Services (CMS)—the federal agency within the Department of Health and Human Services (HHS) responsible for overseeing states' Medicaid programs.⁶ Under HCBS waivers, states can provide HCBS to a specific population, such as individuals with intellectual or developmental disabilities, or limit the number of beneficiaries who can receive HCBS. States must ensure the quality of these waiver programs (referred to in this report as HCBS programs) by, for example, protecting beneficiaries' health and welfare, and providing evidence to CMS that demonstrates quality assurance.

To respond to COVID-19, CMS has approved states' requests to make temporary changes to HCBS programs through an expedited process. With initial guidance from CMS in March 2020, states decided what temporary changes were needed to maintain beneficiaries' access to HCBS and prevent the spread of COVID-19. CMS has described the number of the changes approved as unprecedented. Although time-limited in nature, temporary changes made in response to COVID-19

⁴Information on expenditures on long-term services are derived from Centers for Medicare & Medicaid Services' National Health Expenditure Accounts. They exclude Medicare post-acute care expenditures. Medicaid HCBS expenditures exceeded those for institutional long-term services and supports from 2013 through 2018, the most recent years for which data are available. See Caitlin Murray et al., "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018," (Chicago, Ill.: Mathematica, January 7, 2021).

⁵For purposes of this report, states refers to the 50 states and the District of Columbia.

⁶Medicaid HCBS can operate under multiple authorities. HCBS waivers are authorized in section 1915(c) of the Social Security Act, and states may provide HCBS authorized under additional provisions of the Social Security Act, including sections 1905(a), 1915(i), 1915(j), and 1915(k). States can also administer HCBS programs through demonstrations authorized by section 1115 of the Social Security Act, which authorizes the Secretary of HHS to waive certain federal Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives. 42 U.S.C. § 1315(a). The terms of these demonstrations can require states to follow the requirements of 1915(c) waiver programs. In this report, we refer to programs authorized under 1915(c) waivers and 1115 demonstrations collectively as HCBS programs.

have been in effect since the first quarter of 2020 and are expected to influence program operations going forward.

Given the number and duration of temporary changes to Medicaid HCBS programs in responding to public health emergencies and protecting vulnerable populations, you asked us to review the temporary changes HHS used to respond to COVID-19 and the effects of these changes.⁷ In this report, we

1. describe the temporary changes to HCBS programs for which states obtained approval in response to COVID-19, and selected states' experiences in making these changes; and
2. examine CMS's monitoring and evaluation of the effects of the temporary changes made to HCBS programs.

To describe the temporary changes to HCBS programs that states sought approval for in response to COVID-19, we reviewed a CMS contractor's analysis of requests approved by CMS as of December 3, 2020—the most recently available analysis as of June 2021.⁸ We reviewed both the counts of states receiving approval for various categories of changes, such as increasing provider payment rates, and descriptions of states' requests, such as how much they would increase payment rates. We determined this information is sufficiently reliable for the purposes of our report by comparing the contractor analysis with a similar CMS summary compiled as part of a risk assessment process and with documentation of the temporary changes requested by a nongeneralizable sample of six states: Illinois, Massachusetts, North Carolina, Rhode Island, Washington, and Wyoming. We selected these states to achieve variation

⁷In addition, the CARES Act includes a provision for GAO to report on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic. Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020).

⁸This CMS contractor's analysis includes temporary changes states requested under various federal authorities, including (1) through state plans approved for each state by CMS; (2) demonstrations and waivers approved by CMS under sections 1115 and 1915(c) of the Social Security Act, respectively; and (3) waivers authorized under section 1135 of the Social Security Act when both a public health emergency and a disaster or emergency have been declared.

in terms of geographic location and Medicaid program size in terms of total program expenditures in 2018.⁹

To describe selected states' experiences in making the temporary changes to their HCBS programs, we interviewed state Medicaid officials from the six selected states and used a data collection instrument to obtain relevant information and documentation. This included information, when available, on the number of service planning activities where the delivery method was changed and on expenditures for certain payment changes in 2020.¹⁰ Other information from selected states included actions states took to implement temporary changes, challenges they faced, and data or indicators they used to monitor the effects of these changes on beneficiaries and providers.¹¹

To examine CMS's monitoring and evaluation of the effects of the temporary changes made to HCBS programs, we reviewed relevant CMS documents and interviewed CMS officials. Specifically, to examine CMS's monitoring activities during the COVID-19 emergency, we reviewed guidance and technical assistance resources CMS provided to states during the emergency, requirements for state monitoring, and documentation of initial monitoring efforts and analyses. To examine evaluation activities, we interviewed CMS officials about the agency's plans and past experience in evaluating their response to emergencies. We compared CMS's monitoring and evaluation activities against its *Pandemic Plan*, which provides a framework for CMS's response to pandemics, including monitoring and evaluation activities.¹² In addition, we determined that the information and communication component and monitoring component of federal internal control standards were significant to our objective, including the underlying principles that

⁹Selected states' expenditures on Medicaid services ranged from \$0.6 billion in Wyoming to \$22.2 billion in Illinois in 2018; collectively, these states made up 12 percent of the \$97 billion in national Medicaid HCBS expenditures in fiscal year 2016, the most recent year these data are available for each state.

¹⁰We asked states to describe any limitations to the amounts reported, and we reflect those in the report where relevant.

¹¹Selected states provided examples of challenges they faced, which were illustrative, but not necessarily comprehensive. We did not determine the extent specific challenges that states identified were experienced among all selected states, and so do not identify which states reported experiencing specific challenges.

¹²Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Pandemic Plan*, V. 3.1. Public Release (updated Jan. 11, 2021).

management should use quality information to achieve the entity's objectives and perform monitoring activities.¹³

We conducted this performance audit from June 2020 to September 2021 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

Medicaid HCBS Programs

Medicaid HCBS beneficiaries range from young children to older adults who have physical, cognitive, intellectual, or behavioral health disabilities or conditions. Based on state Medicaid program design, various entities—including state or local government agencies, independent contractors, and HCBS providers—assess beneficiaries' abilities and needs to determine whether they are eligible for HCBS programs and to plan for the services they need.¹⁴

HCBS Programs

States are authorized to cover Medicaid home- and community-based services (HCBS) under multiple authorities. In this report, when we refer to HCBS programs, we refer to those authorized under sections 1915(c) and 1115 of the Social Security Act.

Source: GAO. | GAO-21-104401

- **Functional assessments** measure beneficiaries' abilities and help determine what services they need.
- **Level-of-care evaluations** determine how beneficiaries' service needs relate to the level of care typically provided in an institutional setting, such as a nursing home. These evaluations and other criteria are used to decide if beneficiaries are eligible for certain Medicaid HCBS.
- **Person-centered service plans** (referred to as service plans in this report) should reflect the services and supports important to meeting

¹³GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁴See GAO, *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), 14-15.

beneficiaries' individual needs. Service plans are developed by beneficiaries with case managers or other individuals.

HCBS programs aim to help beneficiaries improve or maintain their abilities and remain safe and healthy in their homes or communities. Core elements of HCBS programs include the following:

- **Service provision.** Generally, HCBS entail assistance with (1) activities of daily living, such as bathing, dressing, and eating; and (2) instrumental activities of daily living, such as preparing meals, housekeeping, and using the telephone.¹⁵ Types of services include, for example, personal care services, such as assistance with bathing and dressing; adult day care services, which provide a range of social, medical, and other services in a group setting; and case management to plan and coordinate services and supports.
- **Providers of care.** Direct care workers—such as personal care aides—are the primary providers of paid HCBS.¹⁶ Family members or legal guardians provide both paid and unpaid care.
- **Settings of care.** This includes provider facilities, such as adult day care facilities, and individual or congregate homes, such as assisted living facilities that provide a residential alternative to nursing homes for individuals who prefer to live independently, but need assistance.
- **Safeguards for beneficiaries.** Safeguards help ensure beneficiaries' health and welfare by detecting, addressing, and avoiding risks of abuse, neglect, and exploitation—known as critical incidents. Safeguards include minimum provider qualification requirements—such as licensing or education requirements—and incident reporting requirements to identify incidents that are severe enough to merit review and follow up.

¹⁵Beneficiaries may be eligible for additional types of HCBS to achieve independence, such as supported employment services.

¹⁶Four occupations often used to categorize direct care workers include (1) home health aides, (2) psychiatric aides, (3) nursing assistants, and (4) personal care aides. See GAO, *Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers*, [GAO-16-718](#) (Washington, D.C.: Aug. 16, 2016).

State and Federal Oversight

States are responsible for the day-to-day administration and oversight of their HCBS programs, including monitoring. For example, states must conduct program integrity activities to help ensure the appropriate use of Medicaid funds, including fingerprint-based criminal background checks for certain HCBS providers and on-site reviews of certain providers.¹⁷

States must also ensure that their HCBS programs meet federal requirements by monitoring and reporting on certain program areas, including systems to ensure provider qualifications and beneficiary health and welfare. For example, states must

- verify that providers meet required standards, such as licensure or certification; and
- identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexplained death.

Federal oversight includes CMS approving and renewing HCBS programs and ensuring states meet program requirements. CMS typically approves HCBS programs for 5-year periods.¹⁸ CMS issues program requirements in the form of regulations and guidance; approves changes states make to their programs; provides technical assistance to states; collects and reviews required information and data from states; and, in some cases, reviews individual state programs to examine states' compliance with requirements or activities to address known deficiencies. The agency collects annual reports from states with information on enrollment and expenditures. These annual reports also include brief descriptions of states' processes for monitoring the program and any findings from this monitoring. Before renewing HCBS programs, CMS also collects quality assurance reports from states that describe findings from states' monitoring and efforts to remediate any issues.

¹⁷CMS requirements for these activities depend on the risk of fraud, waste, and abuse posed by different provider types, as determined by CMS. Newly enrolling home health providers are considered a high risk and therefore subject to fingerprint-based criminal background checks, and all home health providers are considered a moderate risk and therefore subject to on-site reviews.

¹⁸CMS typically renews HCBS programs authorized by sections 1115 and 1915(c) waivers for a 5-year period, although CMS can renew for shorter periods under section 1115. When renewal is required for HCBS provided under different authorities, such as 1915(i), CMS renews for 5-year periods.

Temporary Changes in Response to Public Health Emergencies

During an emergency—such as a public health emergency or a national emergency, both of which were declared in response to the COVID-19 pandemic—states can seek CMS approval to make temporary changes to their HCBS programs through waivers or other program flexibilities.¹⁹ These changes can enable states to address emergencies through modifications that are not otherwise allowed or would require a more extensive review and approval process if made on a permanent basis.

In March 2020, CMS provided states with a list of temporary changes across a number of HCBS program elements that they could request through an expedited process.²⁰ These changes are time limited and are generally scheduled to terminate based on the conclusion of the COVID-19 public health emergency (referred to in this report as the COVID-19 emergency). According to statements made in January 2021 by the Acting Secretary of Health and Human Services at that time, the public health emergency will likely continue at least through the end of 2021. In December 2020, CMS issued guidance on returning to normal operations after the COVID-19 emergency ends.²¹ This guidance recommended that states phase out temporary changes as they are no longer needed to address COVID-19, and established dates for ending temporary changes,

¹⁹For certain types of changes, the HHS Secretary must declare a public health emergency and the President of the United States must declare a national disaster or emergency. See 42 U.S.C. § 1320b–5.

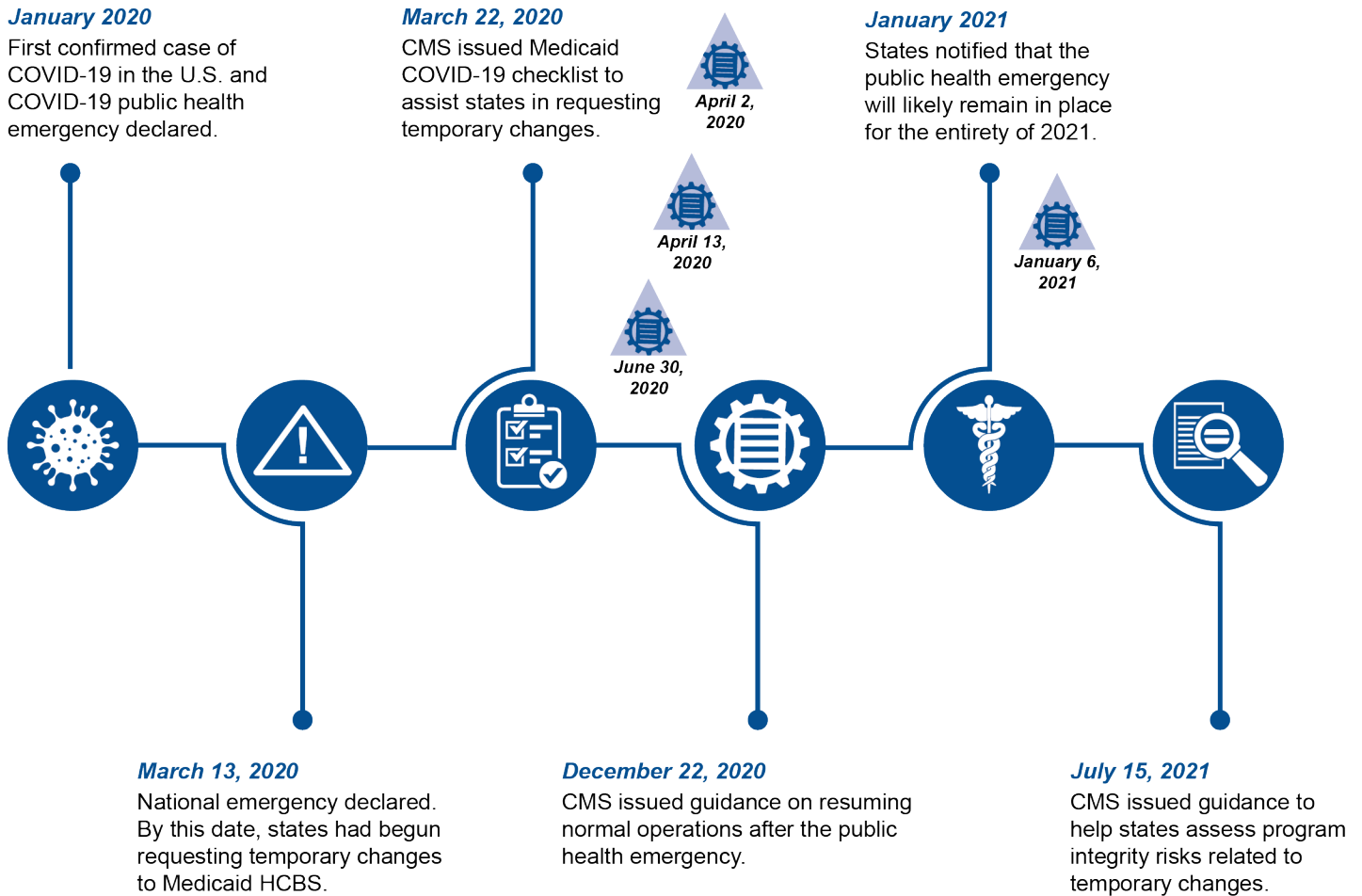
²⁰Department of Health and Human Services, Centers for Medicare & Medicaid Services, *APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum* (Mar. 22, 2020).

²¹Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*, SHO# 20-004 (Baltimore, Md.: Dec. 22, 2020).

which ranged from the conclusion of the COVID-19 emergency to 12 months after.²² (See fig. 1.)

²²According to this guidance, many temporary changes to HCBS must end by the date specified by CMS in approval letters, but states have up to 12 months after the end of the emergency to resume certain HCBS activities, such as annual level-of-care evaluations for existing beneficiaries, for programs operating under certain federal authorities. In August 2021, CMS updated this guidance. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*, SHO# 21-002 (Baltimore, Md.: Aug. 13, 2021).

Figure 1: COVID-19 Public Health Emergency and Responses Related to Medicaid Home- and Community-Based Services (HCBS)



Dates when additional CMS guidance on Medicaid HCBS response to COVID-19 were issued.

Source: GAO analysis of documents from the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS). | GAO-21-104401

Text of Figure 1: COVID-19 Public Health Emergency and Responses Related to Medicaid Home- and Community-Based Services (HCBS)

- January 2020: First confirmed case of COVID-19 in the U.S. and COVID-19 public health emergency declared.
- March 13, 2020: National emergency declared. By this date, states had begun requesting temporary changes to Medicaid HCBS.
- March 22, 2020: CMS issued Medicaid COVID-19 checklist to assist states in requesting temporary changes.

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- December 22, 2020: CMS issued guidance on resuming normal operations after the public health emergency.
 - January 2021: States notified that the public health emergency will likely remain in place for the entirety of 2021.
 - July 15, 2021: CMS issued guidance to help states assess program integrity risks related to temporary changes.

Source: GAO analysis of documents from the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS). | GAO-21-104401

States Pursued a Broad Range of Temporary HCBS Changes; Less In-Person Contact Presented Challenges for Selected States

States pursued a broad range of temporary changes to their HCBS programs in response to COVID-19. Our six selected states implemented these changes quickly, beginning in March 2020, and state officials told us that, in general, only minor adjustments were needed throughout the COVID-19 emergency. While the changes reduced in-person contact to limit the spread of COVID-19, state officials said the changes also led to new challenges in ensuring beneficiaries' health and welfare.

States Pursued Temporary Changes to Core Elements of HCBS Programs that Directly Affected Beneficiaries and Providers

Our analysis of CMS documentation shows that all 51 states received approval from CMS to implement a broad range of temporary changes to core elements of their HCBS programs—service provision, providers, settings of care, and beneficiary safeguards—in an effort to limit the spread of COVID-19 and maintain access to needed services, including by maintaining provider capacity. For example, to reduce the risk of spreading COVID-19, states increased payments to providers to cover the cost of personal protective equipment, such as masks. (See table 1.)

Table 1: Examples of Temporary Changes to States' Medicaid Home- and Community-Based Services Programs in Response to COVID-19 and the Number of States with Approvals as of December 3, 2020

	Program element and temporary change	Number of states approved	Examples of changes approved by CMS
Service provision	Modify level-of-care evaluations	51	Conducting virtual evaluations (via phone or video) of the level of care a beneficiary needs—used to determine eligibility—rather than in-person evaluations, signing evaluations electronically, and extending timelines to complete annual re-evaluations.
	Modify person-centered service planning	50	Conducting service planning virtually (via phone or video) rather than in person and signing plans electronically.
	Exceed service limits	42	Exceeding limits on the amount of care allowed, such as the number of home delivered meals or number of days of respite care.
Providers	Make retainer payments to providers	39	Paying providers experiencing service disruptions, such as beneficiary hospitalizations or the need to isolate due to contracting COVID-19.
	Increase provider payment rates	38	Increasing payments rates for certain providers, which could cover new costs such as purchasing personal protective equipment or providing hazard pay.
Service settings	Expand service settings	49	Providing services in an alternative setting, such as delivering adult day care services in a beneficiary's home rather than in a provider facility.
Safeguards for beneficiaries	Relax provider qualifications requirements	48	Modifying, delaying, or suspending requirements for licensing, certification, or screening, such as submitting providers' fingerprints for criminal background checks.
	Modify incident reporting requirements	26	Modifying or delaying requirements for reporting incidents of risk to beneficiary's health and welfare, such as potential abuse or neglect.

Source: GAO analysis of Centers for Medicare & Medicaid Services documentation. | GAO-21-104401

Note: This table includes all 50 states and the District of Columbia.

States varied in which temporary changes they made to their HCBS programs and in the specifics of the changes. For example, among the 38 states that increased payment rates for HCBS providers, increases ranged from 5 percent to 50 percent. Also, these states applied increases to different types of HCBS such as, in-home services (25 states) or case management (four states). Similarly, states took different approaches to relaxing provider qualification requirements. For example, one of our selected states, Massachusetts, loosened requirements by allowing providers to deliver services while background checks were being completed. Another selected state, Wyoming, received approval to delay provider background checks altogether until after the COVID-19 emergency, though state officials told us that as of May 2021 the state

had resumed checks. States also took different approaches to temporary changes based on differences in their programs.²³ (See table 2.)

Table 2: Examples of Differences in Three States' Temporary Changes to Medicaid Home- and Community-Based Services Programs during the COVID-19 Public Health Emergency

Temporary change	Massachusetts	Washington	Wyoming
Modify level-of-care evaluations used to renew eligibility	Can be delayed until after the emergency.	Can be delayed for a year.	Can be delayed for a year. Abbreviated assessments of beneficiaries can be used for re-evaluations.
Increase payment rates for providers	Ranges from 10 to 50 percent. Increases range from 10 to 25 percent depending on the type of service. Increases up to 50 percent can apply to providers of in-home services to certain beneficiaries who have COVID-19.	Ranges up to 50 percent. Providers of certain services can receive a payment increase up to 25 percent. Providers, such as residential habilitation providers, can receive an increased payment rate up to 50 percent.	Ranges from 12.5 to 15 percent. Increases of 12.5 percent applied to adult day and personal care, while 15 percent increases applied to skilled nursing, assisted living, and home health.
Offer retainer payments to providers	Available for 30 days for providers of habilitation services that closed due to COVID-19.	Available for 30 days for direct care workers or 90 days for adult day care providers if beneficiary is either diagnosed with COVID-19 or quarantined.	Wyoming did not implement this change.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-21-104401

Notes: The table reflects changes approved by CMS as of December 2020 and reflects differences across three temporary changes selected for illustrative purposes. The table does not reflect all of the temporary changes that each state implemented.

Together, the temporary changes significantly altered how beneficiaries received and engaged in HCBS. For example, Medicaid HCBS must be documented in a service plan, which beneficiaries develop with case managers, typically in person. Meeting in person allows the case manager to observe the beneficiary at home when determining service needs.²⁴ To avoid spreading COVID-19, 50 states sought to transition to managing beneficiaries' services virtually—over the phone or video—rather than in person. Of the five selected states that moved to virtual service planning, the three that had available data reported that they collectively completed more than 250,000 service plans virtually in 2020,

²³Some states also pursued different changes among the various HCBS programs within their state, such as varying changes to programs providing services in residential facilities from programs serving beneficiaries in their homes.

²⁴For more information on care management in long-term services and supports, see GAO, *Medicaid Long-Term Services and Supports: Access and Quality Problems in Managed Care Demand Improved Oversight*, GAO 21-49 (Washington, D.C.: Nov. 16, 2020).

most of which would have been conducted in person, according to state officials.²⁵

The temporary changes also directly affected providers by allowing states to make payment changes to address increased provider costs and disruptions to provider revenues.

- **Changes to address increased provider costs.** Adapting to COVID-19 could lead to HCBS providers paying for additional overtime, personal protective equipment, hazard pay, and additional training. For example, Washington state officials reported that providers needed to offer hazard pay to retain staff who were reluctant to provide services in beneficiaries' homes due to fears of contracting COVID-19. Payment rate increases allowed states to address these increased costs. All six selected states implemented payment increases. The four that had available data reported payment increases in 2020 totaling at least \$450 million, ranging from \$3 million in Rhode Island to \$360 million in Washington.²⁶
- **Changes to address provider revenue disruptions.** Some providers—particularly those providing care in congregate settings, such as adult day care providers—faced a complete shutdown of care as a result of public health orders. Others faced disruptions from beneficiary hospitalizations or isolation due to contracting COVID-19 that reduced revenue. Thirty-nine states used retainer payments, which were time limited, to help providers stay in business through those disruptions. The five of our six selected states that implemented retainer payments reported total payments of at least \$98 million in 2020, ranging from \$2 million in Washington to \$59 million in Illinois.²⁷

²⁵Data on the number of service plans conducted virtually were not available from two states—Wyoming and Massachusetts—but officials in Massachusetts told us that such information is documented in individual case files.

²⁶One state that provided data noted its amounts did not include data for all of the state's HCBS programs. In the two remaining states that did not report data—Massachusetts and North Carolina—officials reported that the state did not have data on the amount of spending under the payment rate increases.

²⁷Although these additional payments were made due to the COVID-19 emergency, the emergency also likely decreased other HCBS expenditures, such as payments for services that were suspended. The five states that implemented retainer payments are Illinois, Massachusetts, North Carolina, Rhode Island, and Washington.

Selected States Implemented Temporary Changes Quickly and Made Minor Adjustments over Time

As the extent of the COVID-19 emergency became clear, selected states acted quickly to adapt their HCBS programs. Each of our six selected states obtained approval and began implementing temporary changes in March 2020, the same month that CMS issued guidance to states on the various changes available.²⁸ To implement the changes, these states reported taking various actions including providing communication, conducting training, and leveraging technology. (See table 3.)

Table 3: Six States' Actions to Implement Certain Temporary Changes to Medicaid Home- and Community-Based Services (HCBS) Programs during the COVID-19 Public Health Emergency

Action to implement temporary changes	Number of states that took action	Examples of actions
Issuing guidance to providers	6 of 6	Massachusetts provided written guidance on documentation requirements for retainer payments.
Holding information sessions	6 of 6	Illinois communicated with other state agencies and managed care organizations on implementing the temporary changes.
Providing training to providers and state staff	6 of 6	Wyoming trained public health nurses on using open-ended questions to better assess beneficiaries over the phone or video.
Communicating to beneficiaries about the change	4 of 6	North Carolina hosted phone calls with beneficiaries about the implementation of temporary changes for the various HCBS programs.
Making changes to information technology systems	4 of 6	North Carolina modified its billing and claims systems to avoid duplicate payments to providers receiving retainer payments.
Providing technology to beneficiaries	3 of 6	Washington distributed pre-paid mobile phones to beneficiaries to conduct assessments or service planning over the phone.

Source: GAO analysis of information provided by state officials. | GAO-21-104401

Officials from selected states told us they generally only needed to make minor adjustments to the temporary changes over the course of the emergency. For example, Illinois implemented temporary changes to its HCBS programs in March 2020 and state officials said they subsequently made only minor adjustments to these changes, such as resuming in-person service delivery in some cases, or extending the changes. Also, officials from Washington told us their initial approval allowed the temporary changes they wanted, although they made substantive changes to retainer payment policies by requiring participating providers

²⁸Three states implemented these changes based on approvals received after March 2020 that gave retroactive authorization for temporary changes extending back through March 2020.

to meet new federal requirements. Officials from the five selected states that implemented retainer payments made substantial updates to their retainer payment policies after CMS issued its guidance in June 2020 (see text box).²⁹

Evolving Guidance on the Use of Retainer Payments during COVID-19

Federal Guidance

In March 2020, the Centers for Medicare & Medicaid Services (CMS) responded to COVID-19 by updating a template for applying for temporary changes to certain Medicaid home- and community-based services programs in response to emergencies. The template included the option to make retainer payments to replace the revenue of certain providers whose services were disrupted.

In June 2020, CMS issued guidance placing new requirements on providers receiving retainer payments for more than 30 days. For example, the guidance required providers to attest that they would not lay off staff.

Implications of June 2020 Guidance on Implementing Retainer Payments

In the five of our six selected states that implemented retainer payments, officials indicated that the timing of the guidance created challenges. In particular, states that began implementing retainer payments prior to June 2020 needed to alter their approaches to meet the new guidance.

Officials from one state told us that the June 2020 guidance was challenging to implement in the middle of the pandemic, but they issued new state guidance to providers to ensure compliance. In contrast, in another state, officials told us that as a result of this new guidance, the state decided not to extend retainer payments beyond 30 days.

Source: GAO analysis of Centers for Medicare & Medicaid Services documentation and information provided by selected states. | GAO-21-104401

Selected states maintained approval for temporary changes even as COVID-19 vaccinations increased and cases fell, but state officials reported relying less on these changes over time. As of May 2021, temporary changes remained approved in all of our six selected states. Officials in four of these states said they had begun scaling back their use of the changes. For example, officials from North Carolina said that while they are still maintaining the flexibility for beneficiaries to receive services virtually—such as adult day care—some beneficiaries had begun to return to receiving those services in person.

To monitor the effects of COVID-19 and temporary changes made to HCBS programs, selected states reported using a range of data and input

²⁹One state opted to not continue retainer payments beyond 30 days. CMS made an additional update to its policy, authorizing states to offer retainer payments for three more 30-day periods in 2021 due to the duration of the COVID-19 emergency. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency*, SMD# 21-003 (Baltimore, Md.: May 13, 2021).

from stakeholders, including managed care organizations, providers, and beneficiary groups. For example, selected states monitored:

- **COVID-19 infections among HCBS beneficiaries.** Three of our six selected states reported monitoring COVID-19 infections or services related to COVID-19. For example, North Carolina tracked COVID-19 cases and deaths among Medicaid beneficiaries state-wide and by county; and Wyoming tracked the number of COVID-19 cases, hospitalizations, and deaths among beneficiaries of each of its HCBS programs.
- **HCBS program enrollment and utilization data.** Each of our six selected states monitored data on HCBS program enrollment and utilization, according to state officials. For instance, Rhode Island compared utilization of HCBS services before and during the COVID-19 emergency to monitor access to HCBS.
- **Stakeholder experience.** All six selected states reported regularly communicating with stakeholders to monitor HCBS and the effects of COVID-19 on those services. For example, Rhode Island met regularly with HCBS providers and monitored provider data on staffing levels, according to state officials. Communications with stakeholders were as frequent as every week in three of our selected states (Illinois, Washington, and Wyoming), according to state officials.

Temporary Changes Made by Selected States to Protect from COVID-19 Led to New Challenges in Ensuring Beneficiaries' Health and Welfare

The temporary changes to HCBS programs enabled selected states to limit in-person contact with beneficiaries to avoid spreading COVID-19 while maintaining services, but these changes created new challenges to ensuring beneficiaries' health and welfare. Officials from selected states provided the following examples of these challenges and the actions taken to address them:³⁰

- Assessing beneficiaries' needs over the phone or video rather than in person hindered the ability of providers or case managers to observe beneficiaries' living conditions and capabilities, such as whether

³⁰Selected states provided examples of challenges they faced, which were illustrative, but not necessarily comprehensive. We did not determine the extent specific challenges that states identified were experienced among all selected states, and so do not identify which states reported experiencing specific challenges.

beneficiaries can access their bathroom, enter and exit their home, and take medications as prescribed. State officials directed those completing the assessments to ask beneficiaries additional questions during the virtual assessments to gain a better understanding of their living conditions. Officials in one state said that after resuming in-person visits, case managers have observed problems with beneficiaries' quality of life or living conditions that could have been caught earlier through in-person assessments. For example, case managers observed the need for additional durable medical equipment, home modifications, and assistive technology.

- Reports of abuse or neglect fell in the absence of more routine in-person contact with beneficiaries, creating concerns that incidents of potential or actual harm to beneficiaries were going unreported. Officials from one of our selected states told us the state has used algorithms to target in-person visits to beneficiaries who are particularly vulnerable to lapses in appropriate care, such as being prone to isolation or pressure ulcers, also known as bed sores or pressure sores.³¹
- Some investigations of reported incidents of potential or actual harm to beneficiaries have been delayed or postponed. For example, in one state, reports of more severe types of incidents—such as abuse and neglect—had priority for investigation over others, such as financial exploitation, which have been postponed.
- Conducting virtual reviews of provider facilities limited the ability of reviewers to conduct a complete, visual assessment, because reviewers only see what providers show them over video. Also, the virtual environment does not allow for reviewers to conduct unannounced visits of provider facilities. Conducting unannounced visits of provider facilities can reveal conditions that may require further inspection.
- Re-establishing some quality assurance activities—such as timely inspections of provider facilities—after the COVID-19 emergency ends will take time.³² Officials in one selected state sought additional state appropriations to reduce the backlog of inspections of provider facilities and resume timely inspections.

³¹Pressure ulcers are wounds caused by unrelieved pressure on the skin. They may occur because of a lack of effective care management.

³²For additional information on challenges states will face in resuming normal Medicaid activities after the COVID-19 emergency ends, see [GAO-21-387](#).

CMS Focused on Supporting State Implementation of Temporary HCBS Changes and Conducted Limited Monitoring and Evaluation

CMS Helped States Implement Temporary Changes and Relied on States to Monitor the Changes during COVID-19 Emergency

During the COVID-19 emergency, CMS's priority was to support states in implementing temporary HCBS changes. CMS officials told us that the national scope of the COVID-19 emergency resulted in an unprecedented number of temporary changes being approved. To support states, CMS officials said they issued a substantial volume of guidance and technical assistance to states throughout the emergency. (See table 4.)

Table 4: Examples of CMS Actions to Assist States with Temporary Changes to Medicaid Home- and Community-Based Services (HCBS) due to the COVID-19 Public Health Emergency, March 2020 to May 2021

Type of assistance	Assistance descriptions and examples
HCBS program templates and instructions	In March 2020, CMS issued templates and instructions to outline state options for temporary changes to HCBS programs. For example, these included at least four sets of options to make changes under different HCBS program authorities.
Responses to frequently asked questions	Beginning in April 2020, CMS issued responses to frequently asked questions to describe how states could make temporary changes, including delivering HCBS in alternative settings. CMS periodically updated these responses through January 2021.
Disaster Response Toolkit	In March 2020, CMS updated its online Disaster Response Toolkit for states with new COVID-19 guidance. CMS continued to add resources to the online toolkit throughout the emergency, including information on public health guidelines.
Regular calls with state Medicaid officials	Beginning in March 2020, CMS held weekly calls with states to assist them in responding to COVID-19, including, for example, informing states on options to maintain the provider workforce, avoid unnecessary in-person contact, and continue delivering HCBS.

Source: GAO analysis of documents from the Centers for Medicare & Medicaid Services (CMS). | GAO-21-104401

Officials from several selected states said that CMS's guidance and technical assistance early in the pandemic helped them identify which changes to make to their programs and how to navigate the approval process. For example, officials in one state told us that the Disaster Response Toolkit that CMS updated during the early months of the pandemic helped them decide which changes to employ for their different HCBS populations, and to ensure these changes worked for beneficiaries

in a variety of care settings. Officials from another state said CMS's HCBS waiver template, which included a list of changes that CMS could approve, helped the state consider options they had not initially considered in responding to COVID-19.

Monitoring and Evaluation

Monitoring occurs *during* an event and is an ongoing assessment of performance to help a government agency remain aligned with changing objectives.

Evaluation occurs *after* the event to measure impact, determine effectiveness, and identify corrective actions to address deficiencies on a timely basis.

Source: GAO. | GAO-21-104401

While CMS helped states to implement temporary changes, the agency's efforts to monitor the effectiveness of those changes were limited. CMS lacked procedures for monitoring the effects of temporary changes during an emergency and determining the need for mid-course changes. CMS's *Pandemic Plan* establishes the need for CMS to monitor the efficacy of temporary changes to successfully respond to an ongoing pandemic. However, the *Pandemic Plan* does not detail any procedures for doing so—including what information could or should be collected from states—and, according to agency officials, CMS has no other documented procedures for monitoring temporary changes during an emergency.

CMS officials told us they generally relied on states to monitor the effects of the changes during the COVID-19 emergency, emphasizing that states have the responsibility to monitor their HCBS programs. While CMS has some general requirements for state monitoring of HCBS programs, the agency provided limited guidance to states on what to monitor during the emergency. CMS also did not request or require states to share any data during the emergency that would allow the agency to assess the effectiveness of the temporary changes and determine whether mid-course changes were needed.

- **Limited guidance to states on monitoring temporary changes.** CMS has provided limited guidance to states on monitoring the effects of the temporary HCBS changes during the public health emergency, such as what information to track. During the COVID-19 emergency, states faced different operating environments and the additional objective of limiting disease spread, both of which have implications for monitoring.³³ Though CMS has issued multiple guidance documents during the first year of the COVID-19 emergency to help

³³CMS issued a technical assistance document for states on the implications of COVID-19 for section 1115 demonstration monitoring. The document describes monitoring-related issues that states are likely to face due to the public health emergency. With regard to HCBS, the document suggests states should describe any related shifts in data trends such as gaps in data on safety measures or changes in data on HCBS access when reporting on those trends to CMS. See Centers for Medicare & Medicaid Services, *Implications of COVID-19 for Section 1115 Demonstration Monitoring: Considerations for States*, 2021.

implement the temporary HCBS changes, none of those included guidance on monitoring. In July 2021, CMS issued a voluntary framework to help states address certain risks related to temporary changes. This framework encouraged states to identify program integrity risks—such as paying for services that were not delivered or were not appropriate—and assess whether additional mitigation strategies are needed.³⁴

- **Lack of data collection from states.** According to CMS officials, the agency has not requested or required states to provide either quantitative or qualitative data that would allow the agency to monitor the effectiveness of the temporary changes during the COVID-19 emergency.³⁵ CMS officials told us they sought to limit the administrative burden associated with states monitoring the effects of temporary changes. Further, according to CMS officials, the agency considered issuing regulations during the emergency requiring states to provide monitoring information about HCBS, as it had done for

³⁴The framework CMS provided to states mirrored the framework CMS used to complete a national assessment of program integrity risks associated with temporary changes to Medicaid HCBS. This assessment used GAO's *Framework for Managing Fraud Risks in Federal Programs*, which identifies leading practices. For the purposes of this report, we did not review the extent to which CMS's assessment followed these practices. CMS officials determined that the biggest program integrity risks would occur after the COVID-19 emergency ends, when states must resume normal program integrity activities, such as provider screening, to avoid improper payments. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Risk Assessment Tool for Evaluating COVID-19 Flexibilities and Waivers* (July 15, 2021), and GAO, *A Framework for Managing Fraud Risks in Federal Programs*, [GAO-15-593SP](#) (Washington, D.C.: July 28, 2015).

³⁵While CMS has not requested these data on temporary changes to HCBS, officials from certain states mentioned temporary changes to HCBS during broader conversations with CMS about states' approaches to Medicaid program changes in response to COVID-19, according to CMS officials. Specifically, according to agency officials, CMS interviewed Medicaid directors from seven states in January 2021. CMS officials explained that these interviews did not focus on HCBS, but officials in some of these states identified temporary changes to HCBS—such as retainer payments—as being among the Medicaid program changes that they thought had the greatest impact.

nursing homes, but decided not to do so.³⁶ Agency officials confirmed that they did not have state data on critical incidents (which include incidents of abuse and neglect) and did not know if critical incidents had increased or decreased during the COVID-19 emergency, though the officials said states are required to continue tracking these incidents of actual or potential harm to beneficiaries during the emergency.³⁷ CMS also did not have state data on COVID-19 infections or deaths among HCBS beneficiaries, though CMS was aware that at least nine states were tracking infections and our work with selected states indicated at least three more were doing so. CMS officials said they met regularly with their partners from the Centers for Disease Control and Prevention to identify data on COVID-19 related deaths that CMS could use to monitor Medicaid HCBS, but these efforts had not resulted in usable data as of March 2021.

CMS officials described some limited steps taken to monitor the effects of the temporary changes. For example, CMS analyzed retainer payment data from two states that, according to CMS officials, typically report high-quality data.³⁸ CMS found average retainer payments were slightly lower than previous average payments in one state, and was not able to complete the analysis for the other state, because of data reliability issues. CMS also compiled data on service use to determine the number and percentage of beneficiaries who received home health and personal care services during the COVID-19 emergency.³⁹ However, officials

³⁶CMS officials explained that the agency has infrastructure in place to respond to monitoring information from nursing homes and other institutional providers, whereas it does not have this infrastructure for HCBS. For example, CMS officials said that the agency could help mitigate a COVID-19 outbreak in a nursing home by sending in the team that conducts regular inspections. In contrast, for a COVID-19 outbreak associated with an HCBS provider, CMS does not have the infrastructure to take direct action and would have to rely on states to do so, according to agency officials. For more information on how CMS's oversight differs for HCBS and institutional long-term services and supports see GAO, *Elder Abuse: Federal Requirements for Oversight in Nursing Homes and Assisted Living Facilities Differ*, [GAO-19-599](#) (Washington, D.C.: Aug. 19, 2019).

³⁷Our past work has identified that oversight of state monitoring of HCBS programs is limited by gaps in state reporting, including of critical incidents. See GAO, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed*, [GAO-18-179](#) (Washington, D.C.: Jan. 5, 2018).

³⁸These data are from the Transformed Medicaid Statistical Information System, which CMS uses to collect detailed claims, managed care encounters, and eligibility data from all states.

³⁹These data were also from the Transformed Medicaid Statistical Information System.

explained these data have important limitations and CMS has not used them to measure the effectiveness of temporary changes.

CMS's lack of monitoring procedures and limited monitoring of the effects of the temporary HCBS program changes during the COVID-19 emergency are not consistent with its *Pandemic Plan* or federal internal control standards.⁴⁰ CMS's *Pandemic Plan* establishes that, during a pandemic, the agency will monitor data on the efficacy of temporary changes in order to carry out its role, including ensuring Medicaid beneficiaries maintain access to quality health care.⁴¹ Federal internal control standards state that management should use quality information to achieve objectives and establish and operate monitoring activities to monitor the internal control system and evaluate the results.⁴²

Without monitoring quality information during public health emergencies on the effects of the temporary changes on the HCBS program, CMS cannot assess whether the temporary changes states have implemented are achieving their intended objectives—which for COVID-19 included limiting disease spread and maintaining access to services—and make mid-course changes as needed. Our prior work found that the unprecedented scale of the COVID-19 emergency has stressed the capabilities of federal agencies, and CMS officials told us the emergency has limited the agency's capacity to develop and carry out monitoring procedures.⁴³ Without developing monitoring procedures in advance of future public health emergencies, CMS is unlikely to conduct necessary monitoring.

⁴⁰Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Pandemic Plan*, V. 3.1. Public Release (updated Jan. 11, 2021).

⁴¹CMS's Center for Medicaid and CHIP Service's Strategic Planning Framework, which is a guide to the center's response to a public health emergency, was included as an annex to the *Pandemic Plan*. According to the framework, the center needs to establish a mechanism for monitoring during an emergency and monitoring temporary changes is especially important when the center has approved a large volume of these changes, such as has been the case during the COVID-19 emergency.

⁴²See [GAO-14-704G](#).

⁴³See [GAO-21-387](#).

CMS's Plan to Evaluate the Effects of the Temporary HCBS Changes after the COVID-19 Emergency Is Unclear

As of June 2021, CMS officials said they intend to evaluate the temporary HCBS changes approved in response to COVID-19, but they had no documented plan for doing so. CMS officials told us that planning around evaluating temporary changes after the COVID-19 emergency ends was ongoing, because the emergency remains underway and agency capacity remains limited. CMS officials told us they formed a workgroup to evaluate the various tools CMS provides to states to respond to public health emergencies, including determining whether there is a need to update the templates states use to apply for temporary changes to HCBS programs. However, as of June 2021, the workgroup did not have documentation of its plans, including whether it will evaluate the extent to which the changes helped limit disease spread and maintain access to HCBS.

CMS officials told us they will continue to assess regular state reporting on HCBS program performance after the COVID-19 emergency, including annual HCBS reports and quality assurance reports.⁴⁴ However, it is unclear whether the information included in these reports will allow CMS to determine the effects of the temporary changes, and whether the information will be timely. In particular:

- **Annual HCBS reports.** These reports include information on the number of participants, expenditures, and the steps states have taken to assure program quality. CMS officials told us that these reports would allow them to compare the number of beneficiaries served before the emergency with the number served after the changes expire. However, information on the effects of temporary changes on COVID-19 spread, such as COVID-19 infection or death rates, may not be included in those reports. It is also unclear whether these reports would provide timely information. For our six selected states, the most recent reports that CMS had received as of May 2021 included reporting end dates that ranged from December 2017 to

⁴⁴These reports are required for HCBS programs authorized under section 1915(c).

June 2019, and one state had not submitted a report.⁴⁵ CMS has also approved delays in state reporting due to COVID-19.

- **Quality assurance reports from states.** CMS requires states to submit a quality assurance report on the results of states' quality measures before renewing HCBS programs for 5 years. These measures include, for example, indicators that the state has an incident management system in place to identify and resolve instances of abuse or neglect. The reports also include corrective actions taken by states when performance on a quality measure falls below required thresholds. However, it is unclear whether these reports would provide needed information to evaluate changes made during the emergency. For example, the reports may not indicate how well states prevented the spread of COVID-19. In addition, for states that recently renewed their HCBS programs, these reports will not be due for more than 3 years.⁴⁶

CMS collects other information the agency could leverage to evaluate the effects of the temporary changes made in response to COVID-19. This information includes state utilization data, ongoing program integrity reviews, and evaluation reports from those states that implemented temporary changes through section 1115 demonstrations. States regularly report service use data through CMS's Transformed Medicaid Statistical Information System and, as mentioned above, CMS was already using the data to compile the number and percentage of beneficiaries who received HCBS at both the state and national level. In addition, CMS periodically conducts program integrity reviews of states, which could be leveraged. While reviews done after the emergency may largely focus on the extent to which states are successful in reestablishing compliance with requirements waived during the emergency, such information could be useful in evaluating which changes resulted in longer-term program integrity risks. For temporary changes to HCBS programs authorized by section 1115 demonstrations—which were approved for roughly one quarter of states as of December 2020—CMS required states to provide evaluation reports within one year of the end of the COVID-19 emergency, which could include information on lessons learned.

⁴⁵CMS officials told us that they were working with the state, Rhode Island, to come into compliance with the reporting requirements.

⁴⁶States are required to submit quality assurance reports 18 months prior to the expiration of their HCBS waiver period, which typically last 5 years.

CMS's lack of a documented plan for evaluating its response to COVID-19 makes it unclear whether such an evaluation will occur and inform planning for future emergencies. According to agency officials, CMS had not evaluated the effects of temporary HCBS changes in response to prior emergencies or developed corrective action plans to improve the effectiveness of the changes.⁴⁷ Not evaluating its response would be inconsistent with CMS's *Pandemic Plan*. The plan indicates that CMS anticipates more pandemics related to novel viruses and the need to evaluate its current response to integrate opportunities for improvement into future planning efforts. Specifically, the plan indicates that CMS should consider leveraging qualitative and quantitative results from the agency's response to develop a corrective action plan that informs planning for future emergencies. Though agency officials recognized the importance of evaluation, CMS is likely to continue to face competing priorities after the emergency ends.⁴⁸ Without evaluating its response to the COVID-19 emergency, CMS may miss opportunities to identify areas for improvement and take any needed corrective action as it prepares for future public health emergencies.

Conclusions

COVID-19 is an unprecedented public health emergency in its national scope and duration. It required states and CMS to take swift action to prevent the spread of disease among Medicaid beneficiaries and providers, while also maintaining access to HCBS. In taking these actions, states sought, and CMS approved, the waiver of a range of program requirements designed to safeguard beneficiaries and Medicaid

⁴⁷Examples of prior emergencies for which states received approval to make temporary changes to HCBS programs include the wildfire emergency in California in 2018 and Hurricane Florence in North Carolina in 2018. Other public health emergencies declared due to novel viruses include the H1N1 influenza outbreak in 2009 and the Zika outbreak in 2016.

⁴⁸For example, we have previously found there may be challenges in resuming Medicaid to normal operations after the end of the public health emergency. See [GAO-21-387](#). In addition, CMS may continue the need to implement new policies, including the oversight of temporary enhanced funding for certain Medicaid HCBS expenditures. See American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9817, 135 Stat. 4, 216-17. See Centers for Medicare & Medicaid Services, State Medicaid Director letter No. 21-003, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency* (May 13, 2021).

funds. Many of these temporary changes have now been in place for over a year.

CMS's *Pandemic Plan* indicates that the agency should monitor temporary changes during an emergency and evaluate their impact after the emergency is over. To date, CMS has taken limited actions to monitor, and the agency's plan for evaluating is unclear. While CMS has issued guidance and provided technical assistance that has provided important support to states, none of that support acknowledged the need to monitor the effects of the temporary changes. COVID-19 is the second novel virus in 5 years that has resulted in a declaration of a public health emergency, and CMS anticipates more to come. By not setting monitoring and evaluation as a priority, CMS is missing opportunities to learn from experience. Learning from the COVID-19 emergency could help CMS during future emergencies to protect the health and welfare of beneficiaries and program dollars.

Recommendation for Executive Action

We are making the following two recommendations to CMS:

The CMS Administrator should develop procedures to monitor temporary changes to Medicaid HCBS programs during public health emergencies. This should include procedures for collecting and analyzing data during emergencies on the effects of these changes. (Recommendation 1)

The CMS Administrator should evaluate the temporary changes to Medicaid HCBS programs after the COVID-19 emergency and develop corrective action plans to address any opportunities for improvement it identifies. (Recommendation 2)

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS concurred with both recommendations. HHS's comments are reproduced in appendix I. HHS also provided technical comments, which we incorporated as appropriate.

Regarding our first recommendation—to develop procedures to monitor temporary changes to Medicaid HCBS programs during public health emergencies—HHS agreed with the importance of monitoring during

emergencies, but also noted CMS's and states' capacity constraints to do so. HHS indicated that CMS will conduct an evaluation after the COVID-19 emergency to determine the extent to which monitoring is needed for future public health emergencies, and will seek state input on any future monitoring plans. However, we maintain that taking the next step of developing monitoring procedures, which could be designed with capacity constraints in mind, will prepare CMS to effectively monitor program changes made during future emergencies.

Regarding our second recommendation—to evaluate temporary changes to Medicaid HCBS programs after the COVID-19 emergency and develop corrective action plans to address any opportunities for improvement—HHS expressed its full intention for CMS to conduct an evaluation and address opportunities for improvement. HHS said that planning for this evaluation is ongoing and CMS will conduct the evaluation after the public health emergency has ended.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on GAO's 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 at YocomC@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix II.

A handwritten signature in black ink, appearing to read "Carolyn L. Yocom", with a stylized flourish at the end.

Carolyn L. Yocom
Director, Health Care

List of Committees

The Honorable Patrick Leahy
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The Honorable Richard Shelby
Vice Chairman
Committee on Appropriations
United States Senate

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
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The Honorable Kevin Brady
Republican Leader
Committee on Ways and Means
House of Representatives

Appendix I: 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 HOME-AND COMMUNITY-BASED
SERVICES: EVALUATING COVID-19 RESPONSE COULD HELP CMS PREPARE
FOR FUTURE EMERGENCIES (GAO-21-104401)**

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 examining temporary changes made to Medicaid home and community-based services (HCBS) programs in response to the Novel Coronavirus Disease 2019 (COVID-19).

Medicaid and the Children's Health Insurance Program (CHIP) play critical roles in helping states and territories respond to Public Health Emergencies (PHEs) and disasters, including the outbreak of COVID-19. During a PHE or disaster, the Centers for Medicare & Medicaid Services (CMS) can use various legal authorities to grant states flexibilities that are critical to a state's ability to respond to the crisis expeditiously and to protect and serve the general public. During prior emergencies, as well as during the COVID-19 PHE, states have been able to request CMS approval for a wide range of flexibilities to the services they provide through the submission of Appendix K amendments to 1915(c) waivers, 1135 waivers, 1115 demonstrations, Medicaid State Plan Amendments (SPAs), and CHIP disaster SPAs. States have sought approval for changes to modify eligibility requirements and benefit packages, ensure access to home and community-based services (HCBS), and support health care providers by updating payment rates.

More specifically, in response to the unique nature of the COVID-19 PHE, CMS also granted new flexibilities to state Medicaid and CHIP agencies as they responded to new and specific challenges presented by this pandemic. For example, the impact of stay-at-home orders meant that states needed to ensure that beneficiaries could continue receiving services without putting themselves and providers at risk of contracting COVID-19, and that provider networks would remain in place. As a result, states sought and CMS approved new flexibilities such as those related to the use of telehealth services as well as temporary enhanced reimbursement rates that support provider capacity and additional costs associated with COVID-19. CMS also created and released four checklists to help states request federal waivers and assisted them in identifying other authorities necessary to implement the needed flexibilities in their Medicaid and/or CHIP programs more efficiently. While states are in the best position to understand the need for flexibilities based on local conditions and geographic circumstances within the state, CMS is always available to provide one-on-one technical assistance as needed.

Throughout the course of the COVID-19 PHE, CMS has measured each requested change against the Centers for Disease Control and Prevention (CDC), CMS, federal, and state policies for slowing the spread of COVID-19 and reducing the risk to individual citizens. For instance, state requests to allow services to be delivered remotely was consistent with recommendations to reduce physical contact between people; retainer payments were made to permit day habilitation programs to close and prevent the congregation of individuals in one building while also taking steps to preserve the availability of the provider pool post pandemic; reimbursement rates were increased to allow for the purchase of Personal Protective Equipment (PPE) and to fund overtime

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID HOME-AND COMMUNITY-BASED
SERVICES: EVALUATING COVID-19 RESPONSE COULD HELP CMS PREPARE
FOR FUTURE EMERGENCIES (GAO-21-104401)**

pay in order to reduce the number of individuals interacting with individuals receiving services; and electronic signatures were permitted to reduce contact exposure to COVID-19 on physical documents.

As noted in the GAO's report, CMS's main priority during the COVID-19 PHE, which is still ongoing, has been to support states in implementing temporary changes to their Medicaid and CHIP programs, and as part of this effort, provided a significant amount of guidance and technical assistance to states. Guidance released in the beginning of the PHE in the form of Frequently Asked Questions (FAQs)¹ addressed both risks and risk mitigation strategies states could employ across the Medicaid program, including issues unique to HCBS. CMS also developed and provided states with toolkits on various topics such as telehealth², vaccine administration³, and long-term services and supports⁴ in order to provide states with important information throughout the course of the PHE. Finally, CMS held, and continues to hold, regularly scheduled all-state calls to discuss specific issues states were facing, as well as the federal flexibilities available. CMS also continues to support states during the PHE by publicly posting approved temporary program changes and all-state call materials on Medicaid.gov⁵.

During the PHE, a major focus for both states and CMS has been to assure the health and welfare of the individuals being served through HCBS programs while also meeting the public health directives necessary to slow the spread of COVID-19. Given states' focus and priority on responding to the PHE, CMS granted states extended time to complete items such as quality reporting; however, no major changes were made as to how quality reviews are to be conducted. CMS further clarified that states, as direct administrators of their programs, are required to continue providing oversight of HCBS, including monitoring and reporting on participants' health and welfare.

One of the key measures of the effectiveness of the HCBS program flexibilities is whether they facilitate ongoing service provision despite significant upheaval in service delivery environments. CMS continues to monitor service utilization in several areas, but as the PHE is still ongoing, it is too early to measure the effectiveness of individual HCBS flexibilities. CMS recognizes the value of performing such an evaluation, however given the ongoing nature of the PHE, and the continued state reliance on HCBS program flexibilities, conducting such an evaluation at this time would be premature. As noted in the GAO's report, CMS fully intends to

¹ <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>

² <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>

³ <https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf>

⁴ <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html>

⁵ <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html>

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID HOME-AND COMMUNITY-BASED
SERVICES: EVALUATING COVID-19 RESPONSE COULD HELP CMS PREPARE
FOR FUTURE EMERGENCIES (GAO-21-104401)**

conduct an evaluation of the HCBS program flexibilities granted to states during the COVID-19 PHE at the appropriate time, and planning for such an evaluation is still ongoing.

In response to the unique nature of the COVID-19 PHE, CMS has been conducting risk assessments using the GAO's Framework for Managing Fraud Risks in Federal Programs. In performing these risk assessments, CMS aims to identify and mitigate the risks of fraud, waste, and abuse that could be associated with Medicaid waivers issued during the COVID-19 PHE, and samples of the risk assessments have been shared with states at various COVID-19 webinars, such as at the Medicaid Integrity Institute, and other similar venues. In further support of state program integrity efforts, the Medicaid and Children's Health Insurance Program Coverage Learning Collaborative developed a toolkit to assist states in effectively assessing risks in their programs related to implementing COVID-19 flexibilities, waivers, and requirements. The toolkit was shared with states in July 2021 and includes a slide deck⁶ and risk assessment template⁷ that states may use to inform and guide their own risk assessments across a variety of COVID-19-related policies and program activities. The template is intended to serve as a starting point for states and can be tailored to fit each state's unique capacities as well as current and future program needs.

GAO's recommendations and HHS' responses are below.

Recommendation 1

The CMS Administrator should develop procedures to monitor temporary changes to Medicaid HCBS programs during public health emergencies. This should include procedures for collecting and analyzing data during emergencies on the effects of these changes. **(Recommendation 1)**

HHS Response

CMS concurs with this recommendation.

CMS recognizes the importance of monitoring temporary changes made to Medicaid HCBS programs during future PHEs. However, it is also important to recognize the capacity constraints at both the federal and state level for conducting this type of monitoring in the midst of responding to a PHE. As noted in the GAO's report, CMS's main priority during the COVID-19 PHE has been, and continues to be, supporting states in implementing temporary changes to their Medicaid and CHIP programs in order to allow states to focus on the more immediate needs of their response. Once the COVID-19 PHE has ended, CMS will evaluate the temporary changes made to Medicaid HCBS programs, and will determine the extent to which monitoring of temporary changes during future PHEs is needed. As the direct administrators of their Medicaid programs, states will also have valuable input to provide on the structure and content of any future monitoring plans.

⁶ <https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf>

⁷ <https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx>

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Recommendation 2

The CMS Administrator should evaluate the temporary changes to Medicaid HCBS programs after the COVID-19 emergency and develop corrective action plans to address any opportunities for improvement it identifies. **(Recommendation 2)**

HHS Response

CMS concurs with this recommendation.

Once the COVID-19 PHE has ended, CMS will evaluate the temporary changes made to Medicaid HCBS programs, and will address any opportunities for improvement as necessary. As noted in the GAO's report, CMS fully intends to conduct an evaluation of the HCBS program flexibilities granted to states during the COVID-19 PHE at the appropriate time, and planning for such an evaluation is still ongoing.

Text of Appendix I: 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 HOME-AND COMMUNITY-BASED SERVICES: EVALUATING COVID-19 RESPONSE COULD HELP CMS PREPARE FOR FUTURE EMERGENCIES (GAO-21- 104401)

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 examining temporary changes made to Medicaid home and community-based services (HCBS) programs in response to the Novel Coronavirus Disease 2019 (COVID-19).

Medicaid and the Children's Health Insurance Program (CHIP) play critical roles in helping states and territories respond to Public Health Emergencies (PHEs) and disasters, including the outbreak of COVID-19. During a PHE or disaster, the Centers for Medicare & Medicaid Services (CMS) can use various legal authorities to grant states flexibilities that are critical to a state's ability to respond to the crisis expeditiously and to protect and serve the general public. During prior emergencies, as well as during the COVID-19 PHE, states have been able to request CMS approval for a wide range of flexibilities to the services they provide through the submission of Appendix K amendments to 1915(c) waivers, 1135 waivers, 1115 demonstrations, Medicaid State Plan Amendments (SPAs), and CHIP disaster SPAs. States have sought approval for changes to modify eligibility requirements and benefit packages, ensure access to home and community-based services (HCBS), and support health care providers by updating payment rates.

More specifically, in response to the unique nature of the COVID-19 PHE, CMS also granted new flexibilities to state Medicaid and CHIP agencies as they responded to new and specific challenges presented by this pandemic. For example, the impact of stay-at-home orders meant that states needed to ensure that beneficiaries could continue receiving services without putting themselves and providers at risk of contracting COVID-19, and that provider networks would remain in place. As a result, states sought and CMS approved new flexibilities such as those related to the use of telehealth services as well as temporary enhanced reimbursement rates that support provider capacity and additional costs associated with COVID-19. CMS also created

and released four checklists to help states request federal waivers and assisted them in identifying other authorities necessary to implement the needed flexibilities in their Medicaid and/or CHIP programs more efficiently. While states are in the best position to understand the need for flexibilities based on local conditions and geographic circumstances within the state, CMS is always available to provide one-on-one technical assistance as needed.

Throughout the course of the COVID-19 PHE, CMS has measured each requested change against the Centers for Disease Control and Prevention (CDC), CMS, federal, and state policies for slowing the spread of COVID-19 and reducing the risk to individual citizens. For instance, state requests to allow services to be delivered remotely was consistent with recommendations to reduce physical contact between people; retainer payments were made to permit day habilitation programs to close and prevent the congregation of individuals in one building while also taking steps to preserve the availability of the provider pool post pandemic; reimbursement rates were increased to allow for the purchase of Personal Protective Equipment (PPE) and to fund overtime pay in order to reduce the number of individuals interacting with individuals receiving services; and electronic signatures were permitted to reduce contact exposure to COVID-19 on physical documents.

As noted in the GAO's report, CMS's main priority during the COVID-19 PHE, which is still ongoing, has been to support states in implementing temporary changes to their Medicaid and CHIP programs, and as part of this effort, provided a significant amount of guidance and technical assistance to states. Guidance released in the beginning of the PHE in the form of Frequently Asked Questions (FAQs)¹ addressed both risks and risk mitigation strategies states could employ across the Medicaid program, including issues unique to HCBS. CMS also developed and provided states with toolkits on various topics such as telehealth², vaccine administration³, and long-term services and supports⁴ in order to provide states with important information throughout the course of the PHE. Finally, CMS held, and continues to hold, regularly scheduled all-state calls to discuss specific issues states were facing, as well as the federal flexibilities available. CMS also continues to support states during

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In response to the unique nature of the COVID-19 PHE, CMS has been conducting risk assessments using the GAO's Framework for Managing Fraud Risks in Federal Programs. In performing these risk assessments, CMS aims to identify and mitigate the risks of fraud, waste, and abuse that could be associated with Medicaid waivers issued during the COVID-19 PHE, and samples of the risk assessments have been shared with states at various COVID-19 webinars, such as at the Medicaid Integrity Institute, and other similar venues. In further support of state program integrity efforts, the Medicaid and Children's Health Insurance Program Coverage Learning Collaborative developed a toolkit to assist states in effectively assessing risks in their programs related to implementing COVID-19 flexibilities, waivers, and requirements. The toolkit was shared with states in July 2021 and includes a slide deck⁶ and risk assessment template⁷ that states may use to inform and guide their own risk

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assessments across a variety of COVID-19-related policies and program activities. The template is intended to serve as a starting point for states and can be tailored to fit each state's unique capacities as well as current and future program needs.

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Recommendation 2

The CMS Administrator should evaluate the temporary changes to Medicaid HCBS programs after the COVID-19 emergency and develop corrective action plans to address any opportunities for improvement it identifies. **(Recommendation 2)**

HHS Response

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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

Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Russell Voth (Analyst in Charge), Leslie McNamara, and Marie Suding made key contributions to this report. Other contributors included Carolyn Garvey, Drew Long, Vikki Porter, and Emily Wilson Schwark.

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