



December 2017

# MEDICAID

## CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services

# GAO Highlights

Highlights of [GAO-18-103](#), a report to congressional requesters

## Why GAO Did This Study

With approval from CMS, the federal agency responsible for overseeing state Medicaid programs, states can provide long-term care services and supports for disabled and aged individuals under one or more types of HCBS programs. State and federal Medicaid HCBS spending was about \$87 billion in 2015. Effective needs assessments help states ensure appropriate access to, and manage utilization of, services and therefore costs. States' processes vary, and challenges include the potential for assessors to have conflicts of interest leading to over- or under-estimating of beneficiaries' needs for HCBS.

GAO was asked to examine states' needs assessment processes for provision of long-term services and supports. This report addresses (1) how selected states assess needs for HCBS, and (2) steps CMS has taken to improve coordination and effectiveness of needs assessments, among other objectives. GAO studied six states that varied in terms of assessment tools in use, participation in federal initiatives, HCBS delivery systems, and geographic location; reviewed federal requirements and documents; and interviewed CMS officials and stakeholders.

## What GAO Recommends

GAO recommends that CMS ensure that all Medicaid HCBS programs have requirements for states to address both service providers' and managed care plans' potential for conflicts of interest in conducting assessments. HHS concurred with GAO's recommendation.

View [GAO-18-103](#). For more information, contact Katherine Iritani at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov).

December 2017

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# CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services

## What GAO Found

The six selected states that GAO reviewed used multiple approaches to assess individuals' needs for Medicaid home- and community-based services (HCBS). Each state may have multiple HCBS programs authorized under different sections of the Social Security Act. These programs serve beneficiaries who generally need assistance with daily activities, such as bathing or dressing. States establish needs assessment processes to collect data on functional needs, health status, and other areas that they use to determine individuals' eligibility for HCBS and to plan services, such as the amount of services needed. The selected states varied in the extent to which they used different assessments across HCBS programs and used multiple types of entities—such as state or government agencies, contractors, or providers—to conduct them.

The Centers for Medicare & Medicaid Services (CMS) has taken steps to improve needs assessments but concerns about conflict of interest remain in regard to HCBS providers and managed care plans. HCBS providers may have a financial interest in the outcome of needs assessments, which could lead to overstating needs and overprovision of services. CMS has addressed risks associated with HCBS provider conflicts, such as by requiring states to establish standards for conducting certain needs assessments, but these requirements do not cover all types of HCBS programs. For example, specific conflict of interest requirements are generally not in place for needs assessments that are used to inform HCBS eligibility determinations. In addition, requirements for states to establish standards to address HCBS providers' potential for conflict of interest in conducting needs assessments that are used for service planning do not apply across all programs.

**CMS Conflict-of-Interest Requirements for Needs Assessments Used for Service Planning for Selected Medicaid Home- and Community-Based Services (HCBS) Programs by Authorizing Section of the Social Security Act**

Needs assessments used for service planning	Section 1905(a)	Section 1915(c)	Section 1915(i)	Section 1915(j)	Section 1915(k)
States must address HCBS provider conflicts-of-interest	-	✓	✓	✓	✓

Legend: ✓ = requirement exists; - = no direct requirement exists

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) regulations. | GAO-18-103

Similarly, managed care plans may have a financial interest in the outcome of HCBS assessments used for both determining eligibility and service amounts. Managed care plans could have an incentive to enroll beneficiaries with few needs, as plans typically receive a fixed payment per enrollee. For example, a plan in one state admitted in a settlement with the federal government to enrolling 1,740 individuals, from 2011 through 2013, whose needs did not qualify them. In 2013, CMS issued guidance that managed care plans may not be involved in assessments used to determine eligibility for HCBS, but CMS has not consistently required states to prevent this involvement. Among three states GAO reviewed with managed care HCBS programs, CMS required one to stop allowing plans to conduct such assessments but allowed plan involvement in two states. The absence of conflict-of-interest requirements across all types of HCBS programs and states is not consistent with federal internal control standards, which require agencies to respond to risks to program objectives.

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## Abbreviations

CMS	Centers for Medicare & Medicaid Services
HCBS	Home- and community-based services
HHS	U.S. Department of Health and Human Services
MACPAC	Medicaid and CHIP Payment and Access Commission
TEFT	Testing Experience and Functional Tools

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December 14, 2017

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Charles E. Grassley  
United States Senate

Medicaid, a federal-state health financing program for low-income and medically needy individuals, is the nation’s primary payer of long-term services and supports for children and adults with disabilities and aged individuals. In recent years, the majority of Medicaid spending on long-term services and supports has been for home- and community-based services (HCBS)—that is, services that are provided to beneficiaries in their homes or in other settings that are integrated into their communities rather than in institutional settings such as nursing homes. In fiscal year 2015, federal and state Medicaid spending for HCBS was estimated at \$87 billion, or 55 percent of total Medicaid spending on long-term services and supports. HCBS can enable beneficiaries who are limited in their ability to care for themselves to remain in their homes, maintain their independence, and participate in community life to the fullest extent possible. In administering their Medicaid programs, states have considerable flexibility to establish multiple HCBS programs authorized under different provisions of federal law, which offer states different options for serving beneficiaries. For example, some types of Medicaid HCBS program authorities limit services only to beneficiaries who need a level of care typically provided in an institutional setting.

To receive Medicaid HCBS, beneficiaries generally must meet functional eligibility criteria—which are typically based on factors such as physical and cognitive abilities indicative of a specified level of need for services—as well as financial eligibility criteria.<sup>1</sup> States establish HCBS needs

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<sup>1</sup>We have previously reported on states’ requirements and practices for assessing the financial eligibility of applicants for Medicaid long-term services and supports. See [GAO-12-749](#), *Medicaid Long Term Care: Information Obtained by States about Applicants’ Assets Varies and May be Insufficient* (Washington D.C.: July 2012). To meet the financial eligibility criteria, individuals must have assets that fall below established levels, which vary by state, but are within standards set by the federal government.

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assessment processes that they use to determine whether individuals are functionally eligible for Medicaid HCBS and to develop service plans that specify the scope and amount of services beneficiaries may receive based on their needs.<sup>2</sup> These processes must be consistent with applicable federal requirements, which may vary across HCBS programs. HCBS needs assessments directly affect the efficiency of and access to the Medicaid program, given their key role in informing both states' determination of functional eligibility for HCBS and the development of service plans that reflect the amount of services to be provided. These assessments are conducted using questionnaires or interview guides referred to as assessment tools, and individual states may use different assessment tools. A state may also use different assessment tools for different HCBS programs within the state or for different purposes such as establishing functional eligibility or developing service plans. The Medicaid and CHIP Payment and Access Commission (MACPAC) found at least 124 distinct HCBS needs assessment tools in use nationwide in 2015.<sup>3</sup>

Given the variation in needs assessment tools across and within states, stakeholders have noted potential benefits of moving toward more uniform HCBS needs assessments—either by assessing all individuals with the same assessment tool, or by assessing individuals in specific populations or HCBS programs with distinct tools that gather similar information on a core set of topics for all individuals.<sup>4</sup> For example, the

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<sup>2</sup>Different terms may be used for HCBS needs assessments depending on the purpose of the assessment—such as informing states' determinations of functional eligibility for Medicaid HCBS programs versus informing the development of an HCBS service plan—or depending on the HCBS program. For example, needs assessments that are used to inform states' functional eligibility determinations may be referred to as evaluations of eligibility, level of care evaluations, or functional assessments, and needs assessments used to develop service plans may be referred to as assessments of need, assessments of functional need, or comprehensive assessments. In some state Medicaid HCBS programs, the same needs assessment may be used for both of these separate purposes; in others, different assessments may be used. For purposes of this report, we use the term “needs assessment” to refer to both the assessments that are used to inform state determinations of beneficiaries' functional eligibility for Medicaid HCBS programs and the assessments that are used to inform the development of service plans.

<sup>3</sup>See MACPAC, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: June, 2016).

<sup>4</sup>The use of a single assessment tool or set of tools that gather similar information is variously referred to by different stakeholders and states as a uniform assessment, a universal assessment, or a standardized assessment. For purposes of this report, we refer to the use of a single needs assessment or set of assessment tools that gather similar information as a uniform assessment.

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U.S. Senate Commission on Long Term Care recommended the development and implementation of a single needs assessment tool that could be used across states, programs, and care settings.<sup>5</sup> In addition, MACPAC noted potential benefits of moving to a uniform needs assessment tool, but also challenges such as differing and changing program needs across states and recent state investments in a variety of different tools.<sup>6</sup> The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for federal oversight of Medicaid. Recent CMS initiatives related to HCBS needs assessments were intended to help states collect uniform information across HCBS assessment tools and improve the effectiveness of needs assessments by addressing potential conflicts of interest, which may occur when entities with financial incentives that are tied to the outcomes of needs assessments conduct such assessments.

Given the critical role that needs assessments play in determining Medicaid beneficiaries' access to long term services and supports and states' broad flexibility to structure needs assessments, you asked that we provide information related to the use of needs assessments across states.

In this report, we:

1. describe the needs assessment processes that selected state Medicaid programs used to determine functional eligibility for HCBS and to plan the provision of services, such as the amount of services to provide;
2. describe steps selected states have taken to improve needs assessment processes for HCBS; and
3. evaluate steps CMS has taken to improve the coordination and effectiveness of needs assessment processes for HCBS.

To describe states' HCBS needs assessment processes and the steps states have taken to improve these processes, we conducted case studies of six states. We selected states that varied in the number of assessment tools in use, types of HCBS delivery systems, participation in

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<sup>5</sup>United States Senate Commission on Long -Term Care, *Report to the Congress* (Washington, D.C.: Sept. 30, 2013).

<sup>6</sup>See MACPAC, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: June, 2016).

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key CMS programs related to needs assessments, and geographic location. The six selected states were: Connecticut, Kentucky, Minnesota, New York, North Carolina, and Washington. For each state, we interviewed state officials involved in Medicaid HCBS programs and interviewed or collected information from state advocacy organizations, such as organizations representing beneficiaries that receive HCBS. We reviewed documents related to states' HCBS programs such as CMS program approvals and policy manuals, as well as documents related to the tools states use to assess beneficiaries' needs, such as questionnaires. To supplement the state case studies, we also reviewed relevant publications, such as MACPAC's inventory of the assessment tools that states used, and conducted interviews with representatives from national organizations involved in Medicaid HCBS issues. The scope of this review was to describe states' needs assessment processes for determining HCBS functional eligibility and developing service plans with respect to the amount of services to provide. While we reviewed HCBS needs assessment tools, it was not within the scope of our review to evaluate the benefits or limitations of specific assessment tools or questions, or to assess state compliance with federal requirements governing HCBS programs.

To evaluate steps CMS has taken to improve the coordination and effectiveness of Medicaid HCBS needs assessment processes, we reviewed and analyzed relevant federal statutes and regulations, guidance, and program materials issued by CMS and its contractors. We compared CMS's regulations and guidance across Medicaid HCBS program authorities. We also reviewed evaluations and documentation of key CMS programs related to HCBS needs assessments, and interviewed CMS officials responsible for overseeing state Medicaid HCBS programs and key CMS programs related to HCBS needs assessments. We also reviewed CMS's HCBS program approvals in our selected states and information gathered from our case studies in the states. In addition, we reviewed the relevant standards for internal control in the federal government.<sup>7</sup>

We conducted this performance audit from May 2016 to December 2017 in accordance with generally accepted government auditing standards.

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<sup>7</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#), (Washington D.C.: September, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance the objectives of an entity will be achieved.

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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.

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## Background

Medicaid is jointly financed by the federal government and the states. States administer their Medicaid programs within broad federal rules and according to a state plan approved for each state by CMS. CMS issues program requirements in the form of regulations and guidance, approves changes to states' Medicaid programs, provides technical assistance to states, and conducts other oversight activities. States are responsible for establishing state policies and procedures in accordance with federal requirements. Each state must designate a single state agency to administer its Medicaid program. That agency can delegate programs or functions—such as enrollment in HCBS programs—to other state and local agencies, but is responsible for their supervision.<sup>8</sup> States may provide certain types of HCBS under their state plans. In addition, states may seek permission from CMS to provide HCBS under waivers of traditional Medicaid requirements; for example, in order to provide services to a targeted population or to a limited number of beneficiaries.<sup>9</sup> Both state plans and waivers are developed and proposed by states and must be approved by CMS in order for states to receive federal matching funds for medical expenditures.<sup>10</sup>

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<sup>8</sup>States' Medicaid agencies may not delegate to other entities the authority to supervise the Medicaid state plan or to develop or issue policies, rules, and regulations on program matters.

<sup>9</sup>For example, section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive otherwise applicable requirements that states offering HCBS offer the benefit statewide, offer comparable program benefits to all eligible beneficiaries, and use a single standard to determine income and resources for purposes of eligibility. For purposes of this report, references to "HCBS Waiver" programs refer to HCBS offered under section 1915(c).

<sup>10</sup>Medicaid is jointly financed by the federal government and the states, with the federal government matching most state Medicaid expenditures using a statutory formula generally based on each state's per capita income relative to the national average.

## Types of Medicaid HCBS Programs and Delivery Systems

Medicaid HCBS cover a wide range of services and supports to help individuals remain in their homes or live in a community setting, such as personal assistance with daily activities, assistive devices, and case management services to coordinate services and supports that may be provided from multiple sources. With approval from CMS, states can provide Medicaid HCBS under one or more types of programs authorized under different sections of the Social Security Act, including several state plan and waiver authorities. (See table 1.) States can have multiple HCBS programs operating under different authorities, and these authorities have distinct features such as different functional eligibility criteria. For example, some types of Medicaid HCBS programs only serve beneficiaries who are functionally eligible for an institutional level of care; that is, beneficiaries must have needs that rise to the level of care usually provided in a nursing facility, hospital, or other institution.<sup>11</sup>

**Table 1: Examples of Types of Medicaid HCBS Programs and Functional Eligibility Criteria**

Home- and community-based services (HCBS) program	Authorizing Social Security Act provision	Program description and functional eligibility criteria
State Plan Personal Care Services	1905(a)	States electing to provide personal care services under a state plan option must provide the services to all eligible beneficiaries. State Plan Personal Care Services can serve beneficiaries who need an institutional level of care or those who do not need an institutional level of care, as determined under state criteria.
HCBS Waiver	1915(c)	States may provide a range of HCBS under an HCBS Waiver and can limit eligibility to specific populations or to specific regions. To be eligible for services, beneficiaries must require an institutional level of care, as determined under state criteria.
State Plan HCBS	1915(i)	States electing to provide HCBS under a state plan may establish different benefit packages tailored for different beneficiary populations. States must establish needs -based eligibility criteria less stringent than the state's criteria for institutional level of care.
Self-Directed Personal Assistant Services	1915(j)	Under this authority, states may provide self-directed personal care and related services in conjunction with State Plan Personal Care Services or HCBS Waiver programs the state has in place. Participants may set their own provider qualifications, train their providers, and determine how much they pay for services. Beneficiaries must be eligible for State Plan Personal Care Services or an HCBS Waiver program.
Community First Choice	1915(k)	States electing to provide HCBS under this authority must provide services to all eligible beneficiaries. Beneficiaries must require an institutional level of care as determined under state criteria.

<sup>11</sup>Functional eligibility criteria may also be referred to as level of care criteria.

1115 Demonstration Program	1115	Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. States may provide HCBS under an 1115 Demonstration Program and can target specific populations or regions for demonstration projects. Terms and conditions of program approvals may specify functional eligibility criteria.
Other HCBS	1905(a)	Under this authority, states may provide additional HCBS under state plans to beneficiaries who need an institutional level of care or those who do not need an institutional level of care. In addition, states must provide the mandatory home health benefit for those who need an institutional level of care and may also provide home health for those who do not need an institutional level of care.

Source: Social Security Act and the Centers for Medicare & Medicaid Services. | GAO-18-103

Under some types of HCBS programs, states can tailor their programs to the needs of specific beneficiary populations they choose to target. Common populations that states target with their HCBS programs include:

- older adults and people with physical disabilities,
- people with intellectual or developmental disabilities,
- people with addictions or mental illness, and
- other populations with specific conditions such as traumatic brain injury or Alzheimer's disease.

States use different delivery systems to provide Medicaid HCBS, and these may vary across distinct HCBS programs within a state. Historically, states have predominantly provided HCBS using fee-for-service delivery systems in which states pay providers for HCBS rendered to beneficiaries and billed to the state. Alternatively, under managed care long-term services and supports delivery systems, states contract with managed care plans to provide HCBS to beneficiaries and typically reimburse the plans through capitation payments, which are periodic payments for each beneficiary enrolled under the contract.<sup>12</sup> Managed care plans may contract with HCBS providers to provide services to beneficiaries or may provide services directly. A state may use a combination of fee-for-service and managed care delivery systems

<sup>12</sup>For the purposes of this report, we use the term "managed care HCBS program" to refer to Medicaid programs for which states contract with managed care plans to provide beneficiaries HCBS. Managed care plans can cover long-term services and supports only or include them as a component of a comprehensive managed care program that also includes physical and behavioral health care among services paid for by the capitation rate.

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within or among its HCBS programs. Estimated expenditures on HCBS provided under managed care have grown from \$8 billion in fiscal year 2012 to \$19 billion in fiscal year 2015.<sup>13</sup>

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## Assessments of Individuals' Needs for Medicaid HCBS

Individuals require HCBS because they are limited in their ability to care for themselves due to physical, developmental, or intellectual disabilities, or to chronic conditions. These services can assist beneficiaries with activities of daily living—basic, personal, everyday activities such as bathing, dressing, and eating—or with instrumental activities of daily living, which are other activities that allow individuals to live independently in the community, such as meal preparation or managing finances. States generally assess a beneficiary's needs for HCBS based on designated assessment tools—or sets of questions—that assessors use to collect information from sources such as beneficiaries, caregivers, and health records. Examples of this information include the following:

- Functional support needs: The need for assistance with activities of daily living or instrumental activities of daily living.
- Clinical care needs or medical health concerns: Information on an individual's health history, active diagnoses, medications, and clinical services (e.g., wound care or dialysis).
- Cognitive and behavioral support needs: The loss of memory function, behaviors that pose risks, or adaptive and maladaptive behaviors.
- Beneficiaries' strengths, preferences, and goals.

The needs assessment processes may vary across states and distinct HCBS programs within a state, but typically involves the following key steps:

- States direct potentially eligible individuals to entities that conduct Medicaid HCBS needs assessments.<sup>14</sup>

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<sup>13</sup>Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015* (Apr. 14, 2017).

<sup>14</sup>Individuals may or may not already be enrolled in Medicaid prior to participating in HCBS needs assessments. Because states can have separate financial criteria to determine eligibility for HCBS programs, some individuals' whose income or resources are too high to qualify for full Medicaid benefits may qualify for Medicaid HCBS if their assessed need is sufficient to qualify for Medicaid HCBS.

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- An assessor conducts a needs assessment, generally in a face-to-face setting, using a designated assessment tool to collect information based on methods such as interviews with beneficiaries and caregivers, observation, and review of other sources of information needed to determine functional eligibility for services. Additional information relevant for service planning purposes may be included in this needs assessment, or collected in additional assessments that may occur after an individual is determined eligible for HCBS.
  - Needs assessment results are used to inform determinations of whether an individual meets particular HCBS programs' functional eligibility requirements.<sup>15</sup>
  - Needs assessment results for eligible individuals inform the development of a service plan. The service plan includes the type and amount of services to be provided to the beneficiary within state-specified limits. States may use distinct needs assessments for service planning to collect more detailed information or may use the same assessment that was used to determine functional eligibility. (See fig. 1.)

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<sup>15</sup>Within broad federal requirements, states define the functional eligibility criteria used to determine whether individuals meet eligibility requirements, and these criteria can vary both across states and among distinct HCBS programs within states.

**Figure 1: Assessments of Individuals' Needs for Medicaid Home- and Community-Based Services (HCBS) to Determine Functional Eligibility and Develop Service Plans**

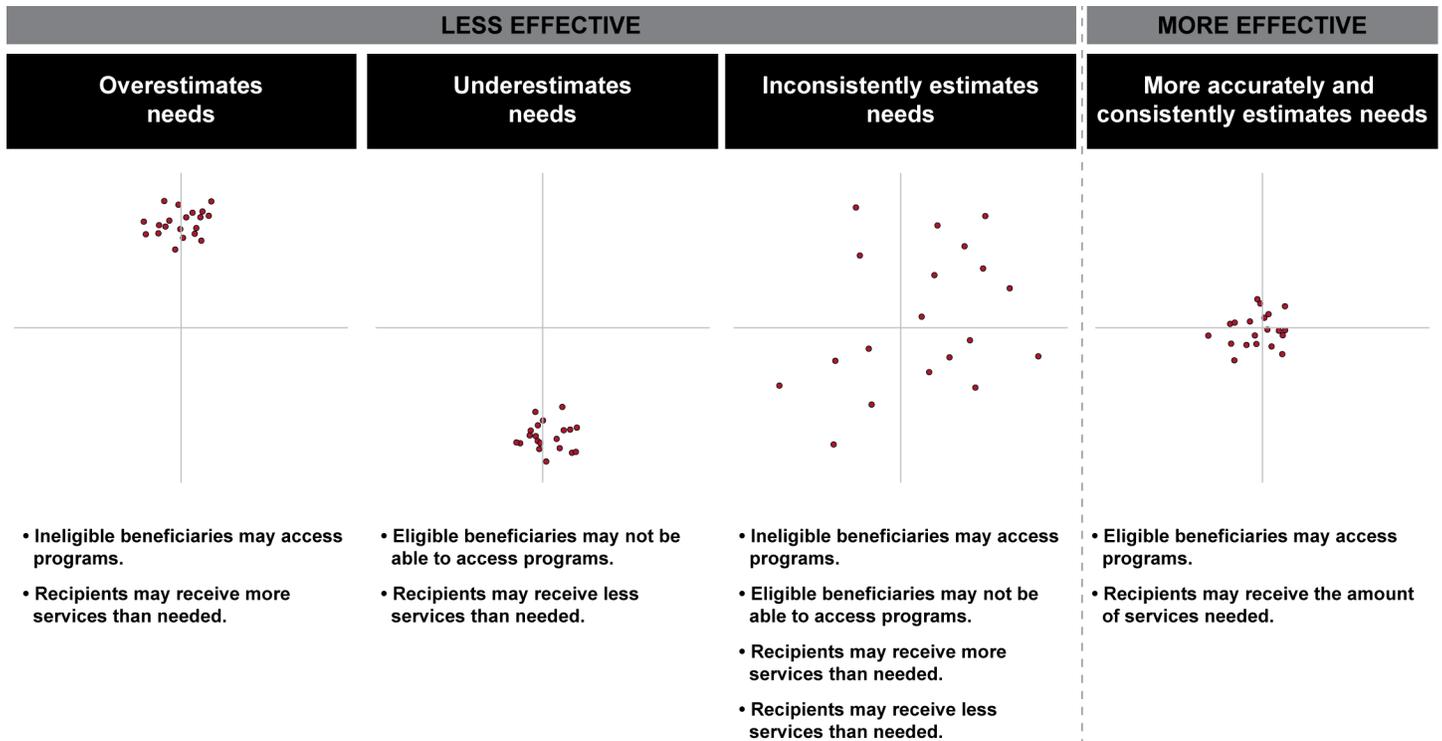


- 1 Individuals who are interested in or may need HCBS are directed to entities that perform assessments of functional needs.
- 2 Assessments are conducted to collect information on functional needs. Additional assessments may provide more detailed information on functional needs or other factors such as strengths, preferences, or goals.
- 3 Assessed needs are used to determine eligibility for HCBS programs.
- 4 Information from assessments is used to develop a service plan, which includes the amount and types of services a beneficiary may receive.

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) regulations and guidance and interviews with CMS and state officials. | GAO-18-103

CMS's goals for HCBS and other Medicaid long-term services and supports include achieving a sustainable and efficient system that provides appropriate services to beneficiaries. Effective needs assessments can help beneficiaries to receive appropriate services to help them live independently and help states manage utilization of services, and therefore costs. An effective assessment process would facilitate efficient use of services and beneficiaries' access to available services appropriate to their needs by accurately and consistently estimating beneficiaries' needs. Assessment processes that overestimate needs, underestimate needs, or both, may result in HCBS programs that offer more services than needed or deny eligible beneficiaries access to needed services. (See fig. 2.)

**Figure 2: Illustration of More and Less Effective Needs Assessment Processes for Medicaid Home- and Community-Based Services Programs and Their Potential Impacts**



Source: GAO. | GAO-18-103

Note: Figure is illustrative and does not represent actual needs assessment results.

There are varied reasons why HCBS needs assessments may not accurately and consistently estimate beneficiaries' needs. HCBS needs assessments cover complex subject matter and may require assessors to make observations and judgments about beneficiaries' needs. For example, needs assessments typically address numerous and varied tasks necessary for a beneficiary to live independently, which can be difficult to measure and subject to interpretation—such as a beneficiary's ability to manage finances. Furthermore, CMS has stated that assessors' conflicts of interest can influence decisions even without individual assessors realizing this. Conflicts of interest can arise when an assessor has an incentive for a beneficiary to either over- or under-utilize HCBS, or an incentive to put the needs of assessors ahead of program goals, such as promoting certain HCBS when others may be more beneficial or cost

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effective.<sup>16</sup> As examples to further illustrate these points, incentives that could result in over- or under-utilization of HCBS include the following, respectively. On one hand, an assessor may be a provider of the services for which the beneficiary may be eligible or a managed care plan that covers these services, and thus have an incentive to find that individuals need the services or coverage they offer. Conversely, a managed care plan may have incentives to reduce enrollees' service utilization in order to reduce costs below the capitation payments that the plan receives to provide care to its enrollees and thus to maximize its profits, which could influence needs assessments used for service planning.

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## Selected States Used Multiple Tools and Entities to Conduct Needs Assessments across Distinct HCBS Programs

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### Selected States Varied in the Extent to Which Needs Assessment Tools Were Tailored to Distinct HCBS Programs and Assessment Purposes

Each of the six selected states we reviewed used varied needs assessment tools across their distinct Medicaid HCBS programs, for which both functional eligibility criteria and amount of services available to beneficiaries can differ widely.<sup>17</sup> The selected states varied in the extent to which their needs assessment tools were either tailored to a single Medicaid HCBS program or used across multiple, though not necessarily all, HCBS programs in the state. The selected states also varied in the extent to which the same or different needs assessment tools were used for different purposes, such as determining functional eligibility and developing a service plan:

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<sup>16</sup>See, for example, Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, 77 Fed. Reg. 26,362, 26,373 (proposed May 3, 2012).

<sup>17</sup>State officials noted that needs assessments are tailored to individual state and HCBS program parameters, which may vary across states as well as for distinct HCBS programs within a given state. States may also set different limits on the amount of services or budget for services that will be available to eligible beneficiaries in distinct programs.

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- **Connecticut.** State officials reported that the state was in the process of piloting a uniform needs assessment tool that it planned to use for all but one of the Medicaid HCBS programs in the state.<sup>18</sup> This needs assessment tool was used both to determine functional eligibility and to develop beneficiary service plans.
  - **Kentucky.** State officials reported that the state had implemented a new needs assessment tool for one Medicaid HCBS Waiver program while continuing to use previous tools for other Medicaid HCBS Waiver programs. The same assessment was used for determining functional eligibility and for developing the service plan. In selecting and adapting the new tool, officials said that they considered the assessment needs of the other Medicaid HCBS waiver programs, because they would ultimately like to use only one assessment tool across all HCBS Waiver programs.
  - **Minnesota.** State officials reported that the state had designed a uniform needs assessment tool for use across all HCBS programs in the state and had implemented it for most programs.<sup>19</sup> The uniform assessment tool was used to determine functional eligibility for all HCBS programs in the state for which it was implemented and was also used to inform the development of service plans.
  - **New York.** State officials reported that the state had implemented a set of needs assessment tools, referred to as a uniform assessment system, for use across multiple HCBS programs. The same uniform assessment system was used to both determine functional eligibility and to inform development of beneficiary service plans.
  - **North Carolina.** At the time of our review, officials described generally using different assessment tools for the separate HCBS programs in the state. State officials reported that the state had developed a new needs assessment tool for one Medicaid HCBS Waiver program, and that they planned to expand use of this tool to another program in the future. The state used different needs assessments to determine functional eligibility and for service planning in its HCBS Waiver programs.

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<sup>18</sup>Officials said that they did not plan to use the new assessment for an HCBS Waiver program serving medically fragile children.

<sup>19</sup>At the time of our review, the assessment was in use for all programs other than for managed care HCBS, for which adoption of the assessment was delayed due to technical issues.

- Washington.** State officials reported that a uniform assessment system was used across HCBS programs in the state. The system was composed of multiple needs assessment components. One version of the assessment was used for HCBS programs serving individuals with intellectual and developmental disabilities, and a different version was used for all other programs. For all HCBS programs, the same needs assessment system was used to determine functional eligibility and to develop the service plan.

**Selected States Used Different Types of Entities to Conduct Needs Assessments, Including State Agencies, Local Public Agencies, Contractors, HCBS Providers, and Managed Care Plans**

All six states we studied reported using more than one type of entity to conduct needs assessments for HCBS programs. For example, New York used five different types of entities, North Carolina used four different types of entities, and the remaining four states used two or three types of entities to conduct needs assessments. State agencies, local public agencies, and independent contractors were used by four states to conduct needs assessments for at least one HCBS program. All states but one, Washington, used HCBS providers or managed care plans to conduct needs assessments (see table 2).

**Table 2: Entities That Conduct Needs Assessments Used for Determining Functional Eligibility or Developing Service Plans for Home- and Community-Based (HCBS) Services in Selected States**

State	Entities that conduct HCBS needs assessments				
	State agency	Local public agency	Independent contractor	HCBS provider	Managed care plan
Connecticut	✓	-	✓	✓	-
Kentucky	✓	-	✓	✓	-
Minnesota	-	✓	-	-	✓
New York	✓	✓	✓	✓	✓
North Carolina	-	✓	✓	✓	✓
Washington	✓	✓	-	-	-

Legend: ✓ Used in at least one state Medicaid HCBS program; - Not used

Source: GAO analysis of interviews with state officials and state HCBS program documents | GAO-18-103

The types of entities that conduct needs assessments in the selected states varied across distinct HCBS programs, or for distinct needs assessment purposes within a single HCBS program. States may use multiple types of entities to conduct needs assessments because of differences in how particular HCBS programs were delivered. For example, the entities used in Minnesota varied by delivery system—the

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state reported that it used local public agencies to conduct needs assessments for all Medicaid HCBS programs other than its managed care HCBS program, for which managed care plans conducted needs assessments. In other states, different entities conducted needs assessments within the same HCBS programs depending on the purpose of the assessment. For example, because managed care plans may have a financial interest in eligibility determinations, New York began by July 2015 to use an independent contractor exclusively to conduct needs assessments to determine functional eligibility for HCBS for new enrollees in its managed care HCBS program. Once individuals were determined eligible for managed care HCBS, the managed care plans conducted the same assessment a second time in order to develop beneficiary service plans.

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### Selected States Varied in Whether Formulas Were Used to Inform Functional Eligibility Determinations and Service Planning Decisions

The six selected states also varied in whether they used formulas based on information collected using Medicaid HCBS needs assessment tools to inform key functional eligibility and service planning decisions.<sup>20</sup> States may use such formulas as a means of meeting goals of consistent treatment of individuals based on needs. In making functional eligibility determinations, five of the six selected states—Connecticut, Minnesota, New York, North Carolina, and Washington—reported using a formula to compare the results of completed needs assessments to eligibility criteria for at least one of the HCBS programs in the state. For example, for specific HCBS programs, the assessment tool may compile results of certain assessment questions into a score that indicates whether or not the beneficiary is considered to have a need for an institutional level of care, which is required in order to be functionally eligible for some types of HCBS programs. For service planning purposes, four states—Connecticut, Minnesota, North Carolina, and Washington—reported that in at least one of these states’ distinct HCBS programs, the assessment tools included formulas. These formulas specified a particular amount of services or guided a potential range of service amounts for beneficiaries based on the results of particular assessment questions. (See table 3.)

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<sup>20</sup>For purposes of this report, we use the term “formula” to refer to decision rules that are used to classify or score needs based on assessment results. Formulas may or may not be automated.

**Table 3: Selected States' Use of Home- and Community-Based Services (HCBS) Needs Assessment Tools with Formulas to Inform Functional Eligibility Determinations and the Amount of Services to Provide**

State	Use of formula to inform functional eligibility determination	Use of formula to inform the amount of HCBS to provide in the service plan
Connecticut	✓	✓
Kentucky	-	-
Minnesota	✓	✓
New York	✓	-
North Carolina	✓	✓
Washington	✓	✓

Legend: ✓ Used in at least one state Medicaid HCBS program; - Not used

Source: GAO analysis of interviews with state officials and state documentation. | GAO-18-103

Notes: This table does not include formulas based on information collected during needs assessments that may be used at the discretion of managed care plans. Eligibility and service planning decisions were not necessarily solely informed by the formula.

Professional judgment may also be used in conjunction with formulas. For example, when formulas are used to specify particular service levels based on the needs assessment results, they may specify a number of service hours or service budget. In either case, other factors may also be considered in some circumstances. State officials in one state described the use of formulas to allocate services as an initial step prior to the detailed person-centered service planning process.<sup>21</sup> For example, in Minnesota a state formula specifies a certain number of hours of personal care services partly based on the level of need for assistance with activities of daily living such as eating, bathing, and toileting. However, the beneficiary and the entity responsible for the service planning process determine the specific services to prioritize within the overall number of hours available, and they may decide to use the authorized hours toward covered services that were not necessarily part of the formula, such as instrumental activities of daily living. In contrast, in states or HCBS programs that did not utilize formulas to specify or guide a particular amount of services based on assessment results, the amount of services may be determined—within the scope of service limits applicable to the particular HCBS program—by the entity responsible for working with the beneficiary on the service planning process.

<sup>21</sup>Under certain HCBS programs, CMS regulations require states to use a person-centered planning process, which generally means that the process is driven by the beneficiary to the extent possible and reflects services that are important for meeting their individual needs and preferences within the limits of the services that are available in that program.

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## Selected States Took Steps to Unify Needs Assessment Processes and Increase Consistency

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### Selected States Made Efforts to Make Needs Assessment Processes More Uniform across Distinct HCBS Programs and Noted Benefits and Challenges

The six selected states reported taking steps to unify needs assessment processes across Medicaid HCBS programs as a means of meeting goals such as improving the efficiency and effectiveness of assessments. Specifically, states reported taking steps to implement assessment tools for use across multiple Medicaid HCBS programs in the state. Four states—Connecticut, New York, Minnesota, and Washington—had adopted or were piloting needs assessment tools that were used across multiple state Medicaid HCBS programs (though not necessarily all such programs in the state) rather than completing separate needs assessments for each separate program. In addition, Kentucky and North Carolina had recently implemented new tools for specific Medicaid HCBS programs that would be considered for use in additional HCBS programs in the future.

Important benefits to beneficiaries and HCBS programs have resulted from efforts to coordinate needs assessment processes by using a uniform assessment across distinct HCBS programs, according to state officials and advocates. For example:

- State officials and advocates described that using a uniform assessment tool to determine functional eligibility for multiple state HCBS programs resulted in benefits and efficiencies for beneficiaries. Officials and advocates in Minnesota said that the uniform assessment process allowed beneficiaries to connect with the program best suited to their needs, even if they may not have otherwise been aware of it when initially seeking assistance. For example, officials said that families of children with autism may apply for personal care services, but may benefit more from being connected to another HCBS program that is available and designed to support the children’s specific needs. Similarly, officials in Connecticut said that uniform assessment across HCBS programs allows beneficiaries to access the services that are most appropriate without

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multiple assessments. For example, if an individual applies for a particular HCBS program but a separate program would be more appropriate, a second assessment is not necessary.

- Connecticut, Washington, and New York officials described how uniform assessment tools allowed consistent information to be shared with care providers or when beneficiaries transitioned between care settings. This, in turn, could allow care providers to better manage beneficiary care.
- State officials reported uniform assessment tools can result in better informed program management and policy decisions because they allow for the ability to collect consistent information across HCBS programs. For example, officials from Connecticut and Washington described how comparable assessment information could inform equitable policies for allocating services. Washington officials described using information about the extent of beneficiary needs to inform decisions about how many program staff were needed. Kentucky officials described how a more uniform assessment process helped them become aware of when beneficiaries were receiving services from multiple different non-Medicaid HCBS programs that were state-funded.

States and advocates also reported challenges, including inefficiencies, to using uniform assessments under certain circumstances, such as when states have different criteria for functional eligibility across their different HCBS programs, or when different beneficiary populations have different assessment needs. For example:

- Minnesota officials reported that beneficiaries may need to address multiple versions of similar eligibility-related questions in its uniform assessment tool. This was due to the decision to incorporate each HCBS program's previously separate functional eligibility questions into its tool to avoid changes in the information they used to determine eligibility.
- Beneficiary advocates in three states expressed concerns with the use of assessments designed for a particular population on a different population, such as using assessments designed for adults to assess the needs of children. Officials from Kentucky also noted concerns about using assessments across distinct populations as part of the reason the state was not using a single assessment tool.
- State officials and advocates also reported that uniform assessments resulted in lengthier assessment question sets that take longer to complete for both the assessor and the beneficiary.

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Selected States Reported Efforts to Increase Consistency in How Needs Assessments Were Conducted and Used, but Balancing Consistency with Flexibility Was a Concern

Selected states reported making efforts to improve their assessment processes to increase consistency in how assessors conduct HCBS needs assessments. These efforts included using structured questions and emphasizing training to ensure individual assessors approached the assessment questions consistently and according to policy, and addressing potential conflicts of interest by using independent assessors rather than HCBS providers and managed care plans to conduct certain needs assessments. States' improvement efforts included the following:

- **Structured questions.** Officials from five states described that structured approaches to assessment questions could improve the consistency of the assessment results, which are used to make functional eligibility and service planning decisions. Examples of structured questions that state officials described included questions that limited responses to a specific time period—such as the past 7 days—when assessing needs, and questions that used a standard scale for responses.
- **Assessor training.** Officials from four states reported focusing on assessor training to improve consistency. For example, North Carolina officials reported that determinations of need for personal care services were improved after training. In the training, assessors were taught to comply with a state policy to ask that beneficiaries demonstrate need for assistance with activities of daily living, such as mobility, rather than solely asking them questions about their needs.
- **Independent needs assessments.** Officials from three of the selected states—New York, North Carolina, and Kentucky—reported that needs assessments were improved by removing entities that had a financial interest in assessment results from conducting certain assessments.<sup>22</sup> For example, Kentucky officials reported that using independent assessors rather than HCBS providers enhanced consistency because HCBS providers may skew beneficiaries' assessment results to generate demand for their services. They noted that providers had resisted their removal from the process.

Three of the six selected states reported that using a formula to summarize assessment results increased the consistency with which functional eligibility determinations or decisions about the amount of services to provide were made based on each individual's assessment results. For example, officials from Washington reported that after

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<sup>22</sup>The other three selected states did not report concerns about conflict of interest.

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implementing a formula to generate an overall classification of need, the amount of service hours authorized for beneficiaries was distributed more equitably and evenly across a continuum from minimum to maximum, rather than beneficiaries mainly always receiving the maximum number of hours allowed under program limits. This could allow for limited resources to be allocated more consistently across beneficiaries with similar levels of need. Officials from Connecticut similarly reported that during testing of a formula that was planned for use to specify the amount of service to provide, they had identified beneficiaries receiving more services than would be indicated by the formula based on their assessed needs.

While officials reported that these efforts enhanced consistency of eligibility determinations and service authorization decisions, state officials and advocates also acknowledged challenges related to balancing consistency with flexibility in arriving at decisions—particularly with respect to the use of formulas for service allocation. The different approaches of relying on a formula or relying on the judgement of individual entities each presented its own challenges:

- In two states where there was a formula to specify or guide the amount of services to provide, advocates raised concerns that the indicated amount did not adequately address needs for some individuals. For example, advocates noted that the results of a lengthy and nuanced assessment tool were ultimately reduced to a single score in order to inform a particular budget for services. While this score might reflect the average needs of beneficiaries with similar assessment results, it did not adequately convey individualized needs of some beneficiaries, according to the advocates.
- On the other hand, there were concerns that relying on entities' judgment resulted in inconsistency across beneficiaries. Advocates in three states raised concerns about inconsistent decisions across managed care plans or geographic areas, or over time, when determinations of functional eligibility or amount of services to provide were not based on state-determined formulas.
- In one state, state officials and advocates noted that these concerns were addressed by using formulas to allocate services but allowing beneficiaries to use an alternative assessment process in certain circumstances or receive "exceptions" to the amount of service authorized by the state's formula based on individual circumstances.

Beneficiary advocates also emphasized that the amount of services that are authorized for beneficiaries may reflect the scope of available services rather than the needs of an individual beneficiary. To the extent

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that a given HCBS program has limited resources for providing services, assessment results may be used to allocate resources within those limitations rather than to estimate the amount of services that would fully meet needs. For example, an assessment formula in Washington is designed to specify service amounts based on beneficiaries' identified levels of need and the amounts that are available for particular levels of need may increase or decrease based on the state budget. State officials in Connecticut also said that because funding can vary for different HCBS programs within a single state, moving to a consistent formula for analyzing assessment results may shed light on the extent that beneficiaries with similar levels of need receive different levels of services depending on available program resources.

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## CMS Has Taken Steps to Make HCBS Needs Assessment Processes More Effective, Uniform, and Free from Conflict of Interest, but Some Concerns Remain Unaddressed

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### Two CMS Programs Have Sought to Make Assessment Processes More Effective and Uniform within and across States

CMS has implemented two key programs that facilitate state efforts to make their HCBS needs assessment processes more uniform, among other goals. One of these is called Testing Experience and Functional Tools (TEFT) and is designed, in part, to test the effectiveness of a set of specific questions that states can use to conduct needs assessments.<sup>23</sup> CMS designed the TEFT assessment questions for use across multiple HCBS beneficiary populations, including beneficiaries (1) of advanced

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<sup>23</sup>Testing needs assessment questions is one component of the TEFT program. The other components include testing the use of a beneficiary experience survey, personal health records that include needs assessment results, and standards to improve the ability to share information electronically that is relevant to HCBS.

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age, or with (2) intellectual or developmental disabilities, (3) physical disabilities, (4) serious mental illnesses, or (5) traumatic brain injuries. The assessment questions being tested are limited to needs that may be relevant among these populations and do not assess needs that may apply to only certain populations; for example, questions to assess cognitive status that may apply to those with intellectual or developmental disabilities or other conditions but that do not apply to those with physical disabilities only. CMS announced TEFT in 2012 and six states received grants to test needs assessment questions for their effectiveness, which includes their validity (defined as accuracy in measuring individuals' functional abilities) and reliability (defined as the consistency of results across assessors).<sup>24</sup> Three of these six states were among those we selected for this review: Connecticut, Kentucky, and Minnesota. Officials in these states told us that they had not completed field testing the TEFT questions, and officials in two of these states (Connecticut and Minnesota) said they would consider the option of using TEFT questions in their assessments in the future. CMS officials told us that CMS plans to make the assessment questions they determine to be valid and reliable available to all states in the spring of 2018.

Another key program that CMS has implemented is the Balancing Incentive Program, which was authorized by the Patient Protection and Affordable Care Act in 2010, to provide incentives for eligible states to rebalance their long-term services and supports systems towards more home- and community-based care.<sup>25</sup> Among other things, this program required participating states to collect information on specific topics related to beneficiaries' needs, but allowed states to choose the needs assessment questions.<sup>26</sup> Under this program, states could use different assessment tools to gather information for HCBS programs serving different populations as long as the states used tools that collected information on 26 key topics that spanned five broad areas, or domains. The five domains were (1) activities of daily living, (2) instrumental activities of daily living, (3) medical conditions/diagnoses, (4) cognitive

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<sup>24</sup>These six states were Arizona, Colorado, Connecticut, Georgia, Kentucky, and Minnesota.

<sup>25</sup>Pub. L. No. 111-148, § 10202, 124 Stat. 119, 923 (2010) (codified at 42 U.S.C. § 1396d note).

<sup>26</sup>The Balancing Incentive Program provided 21 participating states with an enhanced federal matching rate to make certain structural changes to their HCBS programs, one of which was to use standardized assessment instruments.

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functioning, memory, and learning, and (5) behavior concerns (e.g., injurious, uncooperative, or destructive behavior). The requirement to collect information from these five domains for each beneficiary population was designed to promote consistency in determining beneficiaries' needs across HCBS programs, while allowing states to tailor their assessment processes to specific beneficiary populations, according to CMS officials. For example, New York reported collecting information on the required topics using a suite of six assessment tools that varied to reflect differences in beneficiaries' age, population, and other factors.

The Balancing Incentive Program ended in 2015, although some states were provided extensions to carry out planned activities. Of 20 participating states evaluated, 18 successfully carried out the requirement to incorporate the 26 key topics in their needs assessments, according to a program evaluation prepared for the HHS Assistant Secretary for Planning and Evaluation.<sup>27</sup> In addition, CMS has provided information and lessons learned from the Balancing Incentive Program to all states via its website and, according to CMS officials, has done several related presentations. While CMS does not have plans to conduct additional evaluations of assessment tools used by participating states, CMS officials told us that there would be some value to doing so and they may consider it in the future.

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<sup>27</sup>U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Final Process Evaluation of the Balancing Incentive Program* (May 2016). Of the 21 states participating in the Balancing Incentive Program, 3 ended their participation early. One of these states, Nebraska, was not included in this evaluation due to its short period of participation, and another of these states, Indiana, did not complete the requirement to incorporate required topics in its needs assessments.

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## CMS Has Taken Steps to Improve Effectiveness by Addressing the Potential for Conflicts of Interest, but These Steps Do Not Address All Types of Programs or Conflicts

CMS has sought to improve HCBS needs assessments by addressing concerns about the potential for conflicts of interest that HCBS providers and managed care plans may have in conducting assessments.<sup>28</sup> As previously noted, HCBS providers may have a financial interest in providing services that could potentially lead to over-utilization of services, while managed care plans may have a financial interest in increasing enrollments and reducing enrollees' service utilization.

### Addressing HCBS Providers' Potential for Conflicts of Interest

CMS has taken steps to address conflicts of interest that may occur when HCBS providers conduct needs assessments, but gaps remain. The Balancing Incentive Program, which ended in 2015, required the 21 participating states to either separate HCBS provision from needs assessment processes or to take steps to mitigate the potential for conflicts of interest that occur when HCBS providers conduct assessments. In addition, CMS implemented regulations requiring all states to establish standards for conducting needs assessments that address certain potential conflicts for particular types of HCBS programs. The specific requirements may differ by program and whether the assessment is used to determine functional eligibility or develop service plans:

- For example, for State Plan HCBS—a relatively small program that accounted for less than 1 percent of estimated Medicaid HCBS expenditures in fiscal year 2015—states are required to establish conflict-of-interest standards that address both (1) evaluation of eligibility, and (2) needs assessments used to develop service plans. These standards must prohibit HCBS providers from conducting eligibility evaluations and needs assessments for this program, with

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<sup>28</sup>HCBS providers refer to providers that directly provide services to beneficiaries. Managed care plans are not considered service providers unless they directly operate as an HCBS provider entity rather than contracting out service provision.

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certain exceptions in which the potential for conflict of interest must be mitigated.<sup>29</sup>

- Under the HCBS Waiver, Community First Choice, and Self-Directed Personal Assistant Services programs—which collectively accounted for 60 percent of estimated expenditures for Medicaid HCBS in fiscal year 2015—states are required to establish standards that generally prohibit HCBS providers from conducting assessments of need used to develop service plans, but this requirement does not apply to assessments that states may use to determine functional eligibility.<sup>30</sup>
- In addition, for State Plan Personal Care Services programs and other HCBS authorized under Section 1905(a) of the Social Security Act—which collectively accounted for 29 percent of estimated Medicaid HCBS expenditures in fiscal year 2015—regulations do not specifically limit HCBS providers from conducting assessments that states may use to determine eligibility or develop service plans.

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<sup>29</sup>Under State Plan HCBS, authorized under section 1915(i) of the Social Security Act, states are required to establish standards for conducting eligibility evaluations and needs assessments used to develop service plans in order to safeguard against conflicts of interest. These standards must prohibit HCBS providers from conducting these functions, except when the provider is the only willing and qualified agent to perform assessments used to develop service plans, in which case the states' standards must ensure provider entities separate their assessor and provider functions, and states must provide individuals with a clear and accessible alternative dispute resolution process. 42 C.F.R. § 441.730(b) (2016).

<sup>30</sup>In general, while state Medicaid agencies or their delegates that make eligibility determinations may utilize other entities to conduct the needs assessments used to make such determinations, these eligibility determinations ultimately must be made by the state Medicaid agencies or their delegates. See 42 C.F.R. § 431.10(b)(3), (c)(1)(i)(A) (2016). For HCBS Waiver and Community First Choice programs, authorized under sections 1915(c) and 1915(k), respectively, CMS requires states to establish standards that prohibit HCBS providers from conducting assessments used to develop service plans, except when the provider is the only willing and qualified agent to perform these assessments. In this case, states must develop conflict of interest protections that include separating the assessor and provider functions, and states must provide individuals with a clear and accessible alternative dispute resolution process. 42 C.F.R. §§ 441.301(c)(1)(vi), 441.555(c) (2016). Under HCBS Waivers and the Self-Directed Personal Assistant Services program, authorized under section 1915(j) of the Social Security Act, subregulatory guidance and regulations require full disclosure to participants when HCBS providers conduct these assessments or develop service plans. Centers for Medicare & Medicaid Services, *Application for a §1915(c) Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria*, Version 3.5 (January 2015); 42 C.F.R. § 441.468(d) (2016).

Restrictions on HCBS providers do not limit the HCBS providers from giving information to the entity conducting an assessment of need.

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As a result of these differences in requirements across HCBS authorities, there are gaps in federal conflict-of-interest requirements applicable to entities that may conduct needs assessments.<sup>31</sup> For example, several types of HCBS programs have specific requirements for states to establish standards to address potential conflicts of interest when HCBS providers conduct needs assessments that are used for service planning, but there are no equivalent requirements for State Plan Personal Care Services programs. (See table 4). In addition, HCBS providers may conduct certain needs assessments that inform HCBS functional eligibility determinations, but specific conflict of interest requirements are generally not in place for such assessments. With respect to gaps in requirements specific to needs assessments that are used to inform functional eligibility determinations, CMS officials suggested that state agencies' responsibility for making final eligibility determinations addresses conflict-of-interest concerns. Specifically, officials noted that CMS regulations require state agencies to determine eligibility, and that, in doing so, states may consider needs assessments conducted by assessor entities as well as information from other sources.<sup>32</sup> However, states may vary in the extent to which they consider information from other sources. In addition, it is unclear how the requirement that the state maintain responsibility for eligibility determinations addresses potential conflicts of interest when an HCBS provider conducts a needs assessment upon which a determination of eligibility for HCBS may be based.

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<sup>31</sup>Although the Balancing Incentive Program requirements for states to address conflicts of interest applied to all HCBS program authorities generally, its requirements only applied to the 21 states that participated and the program has ended.

<sup>32</sup>See 42 C.F.R. § 431.10(b)(3), (c)(1)(i)(A) (2016).

**Table 4: Selected Medicaid Home- and Community-Based Services (HCBS) Programs, Federal Conflict-of-Interest Requirements Applicable to Needs Assessments for Service Planning, and Estimated Program Expenditures in Fiscal Year 2015**

HCBS program and authorizing section under the Social Security Act	Federal requirements specify that states must establish standards for conducting needs assessments that address HCBS providers' potential conflicts of interest for service planning <sup>a</sup>	Medicaid HCBS estimated expenditures in fiscal year 2015 <sup>b</sup>	
		In billions (dollars)	As a percentage of all estimated expenditures
HCBS Waiver - 1915(c)	✓	\$44.6	51.5%
State Plan Personal Care Services - 1905(a)	-	13.3	15.3
Other HCBS - 1905(a)	-	11.5	13.3
Community First Choice - 1915(k)	✓	7.6	8.7
State Plan HCBS - 1915(i) <sup>c</sup>	✓	0.5	0.6
Self-Directed Personal Assistant Services - 1915(j)	✓	0.1	0.2

Legend: ✓ = requirement exists; - = no direct requirement exists

Source: GAO analysis of Centers for Medicare and Medicaid Services' (CMS) regulations and CMS's and states' data collected and published by Truven Health Analytics, under contract with CMS. | GAO-18-103

<sup>a</sup>Federal regulations specify that state Medicaid agencies are responsible for eligibility determinations. The Medicaid agency may delegate eligibility determinations to other government agencies, but must exercise appropriate oversight over delegated functions. 42 C.F.R. § 431.10(2016). The Medicaid agency or other government agencies that make eligibility determinations may consider information or assessments from other entities.

<sup>b</sup>Expenditure estimates do not include expenditures for managed care programs in California and North Carolina and likely underestimate relevant behavioral health spending due to data limitations. We did not include HCBS programs in this table that account for \$9 billion in estimated expenditures, and so percentages do not add to 100 percent of the \$87 billion estimated expenditures for Medicaid HCBS in fiscal year 2015.

<sup>c</sup>Additional specific requirements apply for eligibility determinations for State Plan HCBS, authorized under section 1915(i) of the Social Security Act. Eligibility must be determined through an independent evaluation of each individual. The independent evaluation is required to include consultation with the individual or their representative and to assess the individual's support needs, among other requirements. 42 C.F.R. § 441.715(d) (2016). States must define conflict of interest standards that ensure the independence of individual and agency agents who conduct the independent evaluation of eligibility. 42 C.F.R. § 441.730(b) (2016).

Gaps in requirements to address the potential for conflicts of interest when HCBS needs assessments are conducted by HCBS providers are not consistent with federal internal control standards, which require federal agencies to identify, analyze, and respond to risks related to achieving defined objectives.<sup>33</sup> While CMS has a goal of achieving an effective long-term services and supports system that provides

<sup>33</sup>GAO-14-704G.

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appropriate services to beneficiaries, because the agency does not require states to address the potential for HCBS providers' conflicts of interest in conducting needs assessments under all HCBS authorities, there is a risk that some states may rely on HCBS providers to conduct assessments without addressing HCBS providers' financial incentives, which can lead to over-utilization of HCBS. Examples among our case study states include:

- **North Carolina:** A program integrity review conducted by CMS in North Carolina found that the state's transition to the use of an independent entity to conduct needs assessments for the State Plan Personal Care Services Program—rather than relying on HCBS providers to assess beneficiary needs—was followed by a reduction in both the number of beneficiaries using the program and a 30 percent reduction in average monthly expenditures.<sup>34</sup> This suggests the program may have been over-utilized before the independent entity was used to conduct needs assessments. CMS highlighted this use of an independent entity as a practice that merits consideration from other states.
- **Kentucky:** State officials told us that when they transitioned to the use of independent assessors they also identified apparent instances of over-utilization that were occurring before they implemented independent assessments and other program changes. For example, officials said that when testing a new assessment tool using independent assessors, they identified individuals who had a low level of needs, and who did not appear to require an institutional level of care, as required for program eligibility, but who had been assessed at that level in the past.

## Addressing Managed Care Plans' Potential for Conflicts of Interest

Conflict-of-interest concerns also exist for states with managed care HCBS programs where managed care plans conduct assessments.<sup>35</sup> CMS has taken separate steps to address these concerns, including issuing guidance and new regulatory requirements.

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<sup>34</sup>HHS CMS Medicaid Integrity Program, *North Carolina Comprehensive Program Integrity Review, Final Report* (April 2012).

<sup>35</sup>Managed care plans are not considered HCBS providers unless they directly provide such services to enrollees. The conflict-of-interest regulations described above generally do not apply to managed care plans unless they also provide services.

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## Functional Eligibility Determinations

CMS issued guidance in May 2013 that addressed best practices and CMS's expectations of new and existing managed long-term services and supports programs, which include managed care HCBS.<sup>36</sup> The guidance stated that managed care plans may not be involved in any HCBS functional eligibility determinations or needs assessment processes prior to a beneficiary's enrollment in the plan.<sup>37</sup> CMS officials told us that allowing managed care plans to assess individuals before enrollment without proper oversight by the state may provide an opportunity for plans to selectively enroll individuals who require less HCBS. Despite this risk, we found that CMS does not always take steps to ensure that states have procedures in place to guard against this practice prior to approving their programs. CMS officials told us that they evaluate state programs individually and may not apply all of the detailed concepts in its guidance when developing state-specific requirements for managed care HCBS programs. CMS's application of the guidance in the three states selected for this review varied across types of HCBS programs. Examples from 1115 Demonstration and HCBS Waiver programs for our case study states include the following:

- **1115 Demonstration programs:** Of the six states we selected for this review, one—New York—operated a managed care HCBS program authorized by an 1115 demonstration. Prior to July 2015, New York used managed care plans to assess and determine individuals' functional eligibility for certain HCBS programs. One managed care plan admitted to enrolling 1,740 individuals in managed care HCBS whose needs did not qualify them for the program from January 2011 to September 2013, and it resolved allegations that it had submitted false claims for Medicaid HCBS in a \$35 million settlement with the U.S. Department of Justice. In 2013, CMS amended the terms and conditions of New York's demonstration to require the state to use an

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<sup>36</sup>CMS, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (May 20, 2013).

<sup>37</sup>In the preamble to a final rule CMS issued in May 2016 to modernize managed care regulations, CMS clarified that the 2013 guidance prohibited managed care plans' involvement in needs assessments conducted prior to enrollment for the purposes of initial eligibility determination, but that managed care plans were expected to conduct needs assessments used for service planning purposes after a beneficiary was enrolled with the plan. 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 Fed. Reg. 27, 498, 27,646 (May 6, 2016).

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independent assessor entity to both conduct needs assessments and determine eligibility for managed care HCBS, and New York has contracted with an independent assessor to carry out these functions. While this requirement applied specifically to New York, it does not necessarily apply to other states, as CMS's terms and conditions for 1115 demonstrations can vary across states. According to CMS, an additional 11 states had managed care HCBS programs approved under 1115 demonstrations as of July 2017. However, CMS officials told us that they did not have information on whether or not these 11 states were using managed care plans to conduct needs assessments for the purpose of determining individuals' functional eligibility.

- **HCBS Waiver programs:** Two of our six selected states—Minnesota and North Carolina—used managed care plans to deliver services for HCBS Waiver programs. In these states, CMS approved HCBS Waiver applications that proposed to use managed care plans to conduct or evaluate needs assessments used to determine functional eligibility for the programs, contrary to CMS's May 2013 guidance. CMS officials said that when states allow managed care plans to be involved in these assessments, CMS would expect states to provide oversight as part of their quality improvement strategies required under HCBS Waivers. However, CMS does not require states to provide assurances or evidence of oversight directly related to managed care plans' potential for conflicts of interest when plans are involved in needs assessments that states use to determine functional eligibility.

CMS officials told us that states that do allow managed care plans to conduct assessments used to determine eligibility for HCBS should be aware of the potential for conflicts of interest in order to provide adequate oversight. CMS officials also told us that they engage in a conversation with states related to oversight of the assessment process when CMS learns of such states. However, CMS does not collect complete information on which states use managed care plans for needs assessments prior to enrollment, and states may not implement precautions absent a specific CMS requirement to address the potential for these conflicts of interest.<sup>38</sup> The absence of requirements for states to

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<sup>38</sup>CMS's regulations specify that state Medicaid agencies are responsible for eligibility determinations. The Medicaid agency may delegate eligibility determinations to other government agencies but must exercise appropriate oversight over delegated functions. The Medicaid or other government agencies that make eligibility determinations may utilize other entities to conduct the needs assessments that the Medicaid or other agencies use to make the eligibility determinations.

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address acknowledged risks is not consistent with federal internal control standards that require federal agencies to identify, analyze, and respond to risks related to achieving defined objectives.<sup>39</sup>

### **Developing Service Plans and Determining the Amount of HCBS to Provide**

Separate concerns pertain to managed care plans' involvement in HCBS needs assessments for service planning purposes that are conducted by plans after enrollment. Advocates in two of the three selected states with managed care HCBS programs, New York and North Carolina, expressed concerns about managed care plans' incentives to reduce their costs by reducing enrollees' HCBS service levels, leading to reduced access to needed HCBS. For example, advocates in New York highlighted the growth in fair hearings that enrollees initiated to dispute reductions in HCBS they receive, which can result from inaccurate needs assessments.<sup>40</sup> In May 2016, in the preamble to a final rule that amended managed care regulations, CMS responded to concerns from commenters about managed care plans' involvement in the needs assessments used to develop service plans by stating that managed care plans' HCBS needs assessments of enrollees are a critical component of the plans' efforts to manage enrollees' care. CMS also noted that existing appeals processes, which are similar to fair hearings, provide adequate safeguards to address instances when enrollees believe their needs assessments do not reflect their true needs.<sup>41</sup> However, according to CMS, beneficiaries enrolled in managed long-term services and supports are among the most vulnerable and often require enhanced protections to assure their health and welfare.

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<sup>39</sup>[GAO-14-704G](#).

<sup>40</sup>These hearings were proceedings in which state officials reviewed managed care plans' actions and determined whether they should be upheld. In New York, advocates reviewed the decisions resulting from fair hearings brought by enrollees to dispute HCBS reductions by managed care plans. These advocates found that 90 percent of the 1,042 fair hearing decisions that occurred over a 7-month period in 2015 were decided in favor of the enrollee, and in 64 percent of the fair hearings, managed care plans withdrew their proposed HCBS reduction or did not appear at the hearing to defend their service reductions. New York state officials said that the rate itself was not necessarily a cause for concern, and that they focus on changes to such rates over time. However, it would be one piece of information among many others to be considered in identifying problematic service reductions.

<sup>41</sup>81 Fed. Reg. at 27, 647.

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To implement additional beneficiary protections, the May 2016 managed care regulations require states with managed care HCBS programs to implement a beneficiary support system. A beneficiary support system generally provides individuals with education and assistance related to appeals, grievances, and fair hearings, and assists states with the identification and resolution of systemic issues through review and oversight of program data. These regulations also require states to report annually on the activities and performance of these systems in order to drive continual improvements. CMS stated that reporting requirements of this nature would help the agency address fragmented program information about state managed care programs and help improve oversight efforts.<sup>42</sup> However, as of September 2017, CMS had not issued guidance to states on the content and form of this reporting, and under the regulations, states are not required to submit reports until CMS issues such guidance. CMS officials told us they were unsure whether they would issue this guidance, and thus it is unclear whether and when the reporting requirement will take effect.

We previously made a recommendation to CMS that pertains to this issue. Specifically, in a report published in August 2017, we identified similar concerns with the lack of requirements for state managed long-term services and supports programs to report information that CMS needs to adequately oversee states' programs for ensuring beneficiary access to services.<sup>43</sup> We found that existing state reporting did not always include key elements necessary for CMS to monitor certain key aspects of beneficiaries' access and quality of care, including data related to appeals and grievances. We recommended that CMS improve its oversight of managed long-term services and supports by taking steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services. HHS concurred with this recommendation and stated that the agency will take this recommendation into account as part of an ongoing review of the 2016 managed care regulations. This action could help to address the concerns discussed above regarding managed care plans' potential for conflicts of interest in conducting needs assessments for service planning purposes.

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<sup>42</sup>81 Fed. Reg. at 27, 717.

<sup>43</sup>See 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).

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## Conclusions

HCBS needs assessments can directly affect whether individuals are eligible to receive HCBS and the amount of services they receive. Given the growth in spending for Medicaid HCBS and the potential vulnerability of individuals seeking HCBS, it is critical that needs assessments are effective in ensuring that beneficiaries receive the help they need to live independently while at the same time reducing the risk of over-utilization of HCBS. CMS plays an important role in ensuring that states appropriately assess the needs of those seeking HCBS, including addressing the potential for entities that conduct needs assessments to have conflicts of interest. Conflicts of interest can result in inaccurate assessments, potentially leading to provision of unnecessary services or restricting other beneficiaries' access to needed services. CMS has required states to take actions to avoid or mitigate the potential for conflicts of interest for some HCBS programs, and states that have taken steps to protect against conflicts of interest in HCBS programs have reported improvements; however, we found gaps in federal requirements for such safeguards. These gaps in requirements are inconsistent with federal control standards that require federal agencies to identify, analyze, and respond to risks related to achieving defined objectives. CMS could improve the efficiency and effectiveness of Medicaid HCBS programs by taking additional steps to consistently require all types of states' programs to avoid or mitigate the potential for conflicts of interest in conducting needs assessments, as appropriate.

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## Recommendation for Executive Action

The Administrator of CMS should ensure that all types of Medicaid HCBS programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments that are used to determine eligibility for HCBS and to develop HCBS plans of service. These requirements should address both service providers and managed care plans conducting such assessments. (Recommendation 1)

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## Agency Comments and our Evaluation

We provided a draft of this report to HHS for review and comment, and HHS provided written comments, which are reprinted in appendix I. HHS also provided technical comments, which we incorporated as appropriate. HHS concurred with our recommendation to ensure that all types of Medicaid HCBS programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments. HHS stated that it has a regulatory structure in place to protect against potential conflicts of interest on the part of entities

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responsible for determining eligibility for HCBS and developing service plans. As described in our report, however, there are gaps in required conflict of interest standards applicable to entities that conduct needs assessments that inform HCBS eligibility determinations. Further, the conflict of interest requirements related to service plans do not apply to all programs, such as State Plan Personal Care Services programs. Developing additional requirements in response to such gaps would further improve efficiency and effectiveness.

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

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

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive style with a large, looped initial "K".

Katherine M. Iritani  
Director, Health Care

# Appendix I: 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

NOV 13 2017

Katherine M. Iritani  
Director, Health Care Team  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICAID: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services*" (GAO-18-103).

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

Sincerely,

A handwritten signature in cursive script that reads "Barbara Pisaro Clark".

Barbara Pisaro Clark  
Acting Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: CMS SHOULD TAKE ADDITIONAL STEPS TO IMPROVE ASSESSMENTS OF INDIVIDUALS NEEDS FOR HOME- AND COMMUNITY-BASED SERVICES (GAO-18-103)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on Medicaid and assisted living. HHS takes seriously its effort to oversee access and quality in states' home and community-based services programs to support the health and welfare of beneficiaries that receive these services under Medicaid waivers.

In an effort to strengthen community living options for older Americans and people with disabilities, HHS issued a final rule in 2014<sup>1</sup> that set forth requirements for several Medicaid authorities under which states may provide home and community-based long-term services and supports. The regulation enhanced the quality of home and community-based services and provided additional protections to individuals that receive services under these Medicaid authorities. In particular, states are required per 42 CFR 441.301(c)(1)(vi) to separate person-centered service plan development from service delivery functions in order to address the potential conflict of interest concerns between providers and managed care plans.<sup>2</sup> In addition, consistent with long standing policy, Medicaid regulations at 42 CFR 431.10 require that the state Medicaid agency be responsible for home and community based service eligibility determinations. As such, regardless of who performs the needs assessment, states evaluate an applicant's need for waiver services and make the final determination of eligibility.

To assist with implementation of home and community based services, HHS offers technical assistance resources to states and providers. In particular, HHS offers a training series, which has included webinars focused on conflict of interest standards. For example, in January 2016, HHS conducted a webinar to assist states in identifying situations where a conflict of interest exists and to guide states through mitigating and implementing new policy to alleviate conflicts of interest across different Medicaid authorities. Lastly, HHS has worked to develop a cross-functional assessment tool which will support state and entities' voluntary efforts to enhance data exchange and interoperability across home and community based service care settings.

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

**GAO Recommendation**

CMS should ensure that all types of Medicaid home- and community-based services (HCBS) programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments that are used to determine eligibility for HCBS and to develop plans of service. These requirements should address both services providers and managed care plans conducting such assessments.

**HHS Response**

<sup>1</sup> 79 FR 2948

<sup>2</sup> See also 42 CFR 441.555(c)(5) for 1915(k) requirements

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: CMS SHOULD TAKE ADDITIONAL STEPS TO IMPROVE ASSESSMENTS OF INDIVIDUALS NEEDS FOR HOME- AND COMMUNITY-BASED SERVICES (GAO-18-103)**

HHS concurs with this recommendation. As mentioned above, HHS already has a regulatory structure in place to protect against potential conflicts of interest on the part of entities responsible for determining eligibility for HCBS and the development of person-centered service plans. In an effort to address conflict of interest concerns, states are required per 42 CFR 441.301(c)(1)(vi) and 42 CFR 441.555(c)(5) to separate person-centered service plan development from service delivery functions in order to address the potential conflict of interest concerns between providers and managed care plans. In addition, Medicaid regulations at 42 CFR 431.10 require the responsibility for home and community based service eligibility to be that of the individual state's Medicaid agency. As such, states are required to evaluate an applicant's need for waiver services and make the final determination of eligibility.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

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

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## Staff Acknowledgments

In addition to the contact named above, Tim Bushfield (Assistant Director), Emily Beller Holland, Anne Hopewell, Laurie Pachter, Chris Piccione, Vikki Porter, Russell Voth, and Jennifer Whitworth made key contributions to this report.

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