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.

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.