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January 2018

MEDICAID ASSISTED LIVING SERVICES

Improved Federal Oversight of Beneficiary Health and Welfare Is Needed

GAO-18-179

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GAO Highlights

Highlights of GAO-18-179, a report to congressional requesters

Why GAO Did This Study

The number of individuals receiving long term care services from Medicaid in community residential settings is expected to grow. These settings, which include assisted living facilities, provide a range of services that allow aged and disabled beneficiaries, who might otherwise require nursing home care, to remain in the community.

State Medicaid programs and CMS, the federal agency responsible for overseeing the state programs, share responsibility for ensuring that beneficiaries' health and welfare is protected. GAO was asked to examine state and federal oversight of assisted living services in Medicaid. This report (1) describes state spending on and coverage of these services, (2) describes how state Medicaid agencies oversee the health and welfare of beneficiaries in these settings, and (3) examines the extent that CMS oversees state Medicaid agency monitoring of assisted living services.

GAO surveyed all state Medicaid agencies and interviewed officials in a nongeneralizeable sample of three states with varied oversight processes for their assisted living programs. GAO reviewed regulations and guidance, and interviewed CMS officials.

What GAO Recommends

GAO recommendations to CMS include clarifying state requirements for reporting program deficiencies and requiring annual reporting of critical incidents. HHS concurred with GAO's recommendations to clarify deficiency reporting and stated that it would consider annual reporting requirements for critical incidents after completing an ongoing review.

View GAO-18-179. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

State Medicaid agencies in 48 states that covered assisted living services reported spending more than $10 billion (federal and state) on assisted living services in 2014. These 48 states reported covering these services for more than 330,000 beneficiaries through more than 130 different programs. Most programs were operated under Medicaid waivers that allow states to target certain populations, limit enrollment, or restrict services to certain geographic areas.

With respect to oversight of their largest assisted living programs, state Medicaid agencies reported varied approaches to overseeing beneficiary health and welfare, particularly in how they monitored critical incidents involving beneficiaries receiving assisted living services. State Medicaid agencies are required to protect beneficiary health and welfare and operate systems to monitor for critical incidents—cases of potential or actual harm to beneficiaries such as abuse, neglect, or exploitation.

- Twenty-six state Medicaid agencies could not report to GAO the number of critical incidents that occurred in assisted living facilities, citing reasons including the inability to track incidents by provider type (9 states), lack of a system to collect critical incidents (9 states), and lack of a system that could identify Medicaid beneficiaries (5 states).
- State Medicaid agencies varied in what types of critical incidents they monitored. All states identified physical, emotional, or sexual abuse as a critical incident. A number of states did not identify other incidents that may indicate potential harm or neglect such as medication errors (7 states) and unexplained death (3 states).
- State Medicaid agencies varied in whether they made information on critical incidents and other key information available to the public. Thirty-four states made critical incident information available to the public by phone, website, or in person, while another 14 states did not have such information available at all.

Oversight of state monitoring of assisted living services by the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is limited by gaps in state reporting. States are required to annually report to CMS information on deficiencies affecting beneficiary health and welfare for the most common program used to provide assisted living services. However, states have latitude in what they consider a deficiency. States also must describe their systems for monitoring critical incidents, but CMS does not require states to annually report data from their systems. Under federal internal control standards, agencies should have processes to identify information needed to achieve objectives and address risk. Without clear guidance on reportable deficiencies and no requirement to report critical incidents, CMS may be unaware of problems. For example, CMS found, after an in-depth review in one selected state seeking to renew its program, that the state lacked an effective system for assuring beneficiary health and welfare, including reporting insufficient information on the number of unexpected or suspicious beneficiary deaths. The state had not reported any deficiencies in annual reports submitted to CMS in 5 prior years.

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Abbreviations

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

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January 5, 2018

The Honorable Susan M. Collins
Chairman
Special Committee on Aging
United States Senate

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Claire McCaskill
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Elizabeth Warren
United States Senate

Medicaid, a federal-state program for low-income and medically needy individuals, is the nation's primary payer of long-term care services for older adults and people with disabilities. Medicaid spending on long-term care is significant, representing about one quarter of Medicaid spending annually and is expected to grow with an aging population. In recent years, most states have expanded their Medicaid long-term care options to include more home and community-based services (HCBS), which may include services provided by assisted living facilities. Federal and state Medicaid spending on HCBS exceeds the amount spent on nursing home and other institutional care and, in 2015, totaled $87 billion.[1]

Assisted living facilities provide a residential alternative to nursing home care for individuals who prefer to live independently but need assistance to maintain their independence. They may provide residents with a variety of services to assist with activities of daily living, such as bathing and

[1]HCBS expenditures grew from $81 billion in FY 2014 to $87 billion in FY 2015 (a seven percent increase), accounting for all the growth in expenditures in FY 2015 for long-term services. *See Medicaid Expenditures for Long-Term Services and Supports in FY 2015.* Truven Health Analytics, Washington, D.C. April 14, 2017.

dressing.[2] Medicaid beneficiaries receiving assisted living services include older adults and individuals with physical, developmental, or intellectual disabilities, some of whom can be particularly vulnerable to abuse, neglect, and exploitation.

The federal government and states both have responsibilities for the health and welfare of beneficiaries receiving assisted living services and other types of HCBS covered by Medicaid. Under broad federal requirements, each state administers Medicaid under the oversight of the Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS). States must obtain CMS approval to establish HCBS programs including those that cover assisted living services, and are then responsible for administering their approved programs, establishing policies and procedures to monitor the service providers, and safeguarding beneficiaries' health and welfare. CMS has important oversight responsibilities to ensure states are effectively administering and monitoring Medicaid HCBS programs, including those that cover assisted living services. With approval from CMS, states can provide Medicaid HCBS under one or more Medicaid authorities, including several state plan and waiver authorities. States most frequently provide assisted living services under the HCBS waiver program, which allows states to target certain populations, limit enrollment, or restrict services to certain geographic areas.[3]

The demand for assisted living services is expected to increase as a result of the aging of the nation's population, increased life expectancy, and increased opportunities to remain in the community for individuals with disabilities and older adults—those 65 and older, generally referred

[2]Services that help beneficiaries with activities of daily living are common home and community based services and may be rendered by a variety of providers. For purposes of this report, when these services are provided by assisted living facilities, we refer to them as assisted living services.

[3]HCBS waivers are authorized under Section 1915(c) of the Social Security Act. Section1915(c) 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 our report, we refer to programs authorized under Section 1915(c) as HCBS waiver programs.

CMS has recently approved states' increased use of managed care to provide long-term services, where states contract with managed care organizations to provide a specific set of covered services to beneficiaries in return for one fixed periodic payment per beneficiary—typically, per member per month.

to as aged individuals. Providing these services to individuals can be cost saving for the Medicaid program because the cost of nursing home care for an individual generally exceeds the cost of assisted living facility services.

Although the federal government has comprehensive information on nursing homes providing Medicaid services, not much is known about Medicaid beneficiaries in assisted living facilities. Current information on the amount spent by Medicaid on assisted living services and number of beneficiaries receiving services provided by assisted living facilities is not available.[4]

In light of the expected increase in demand for assisted living services, the vulnerability of some Medicaid beneficiaries receiving these services, and limited information on the varied state programs under which they are provided, you asked us for information on Medicaid coverage of assisted living services and state and federal oversight of the health and welfare of beneficiaries receiving these services. This report

1. describes state Medicaid programs covering assisted living services, including spending, beneficiaries served, and services covered;
2. describes how state Medicaid agencies oversee the health and welfare of beneficiaries receiving assisted living services in their largest programs; and
3. examines the extent to which CMS oversees state Medicaid agencies' monitoring of the health and welfare of beneficiaries receiving assisted living services under HCBS waivers.

To describe state Medicaid programs providing assisted living services, we administered a survey to all states and the District of Columbia

[4]In a 2012 report, 35 states reported to the Health and Human Services' Office of Inspector General that HCBS waiver programs covered assisted living services for more than 54,000 beneficiaries at an annual cost of $1.7 billion in 2009. See U.S. Department of Health and Human Services, Office of Inspector General, *Home and Community Based Services in Assisted Living Facilities*, OEI-09-08-00360, December 2012.

(hereafter referred to as "states").[5] As part of this survey we asked states to report information for all of their programs that provided such services in 2014. Information requested included Medicaid spending for such services in 2014, enrollment, type of beneficiaries served, services provided, and federal authority used to cover the different assisted living programs.[6] We conducted the survey from December 2016 through March 2017, and received a response from all states. We did not independently verify the information reported by the states in the survey, but reviewed responses and followed up with state officials when reported information appeared inconsistent or needed clarification. On that basis we believe the data are reliable for the purposes of our reporting objectives.

To describe how state Medicaid agencies oversee the health and welfare of beneficiaries receiving assisted living services, we relied on information obtained from our survey of states. Because a state may have multiple programs covering assisted living services within the state, and these programs may be overseen in different ways, we focused our work on examining states' oversight of their largest programs. In particular, we asked each state to report 2014 information only for its largest HCBS program in terms of number of aged beneficiaries receiving services provided by assisted living facilities.[7] These results cannot be generalized to all HCBS program types within a state or nationally. Assessing whether

[5]According to the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, states vary—sometimes considerably—in how they define assisted living with most states using the phrase assisted living as a licensing or certification category followed by different terms such as facility, residence, program, home, and community. For purposes of the survey, we defined assisted living facility broadly to include a state or locally regulated and monitored residential care setting that provides or coordinates services to meet residents' individualized needs. Other terms which are used include residential care, adult homes, personal care homes, boarding homes, and homes for the aged, and other state-specific variations. Our definition did not include services provided in an individual's home or family member's home.

[6]For purposes of the survey, we asked states to report for 2014, the amount of total Medicaid spending for services provided by assisted living facilities. Home- and community-based services may be furnished by individual providers or by assisted living facilities. We asked states to include only instances where Medicaid paid the assisted living facility directly.

[7]For purposes of this report, we refer to the program selected by each state as its "largest program." We asked states to identify the program that enrolled the greatest number of older adults. However, the programs identified by states included other beneficiary populations, such as the physically disabled, intellectually disabled, and those with traumatic brain injuries.

states' oversight activities were compliant with federal requirements was not within the scope of this review.

To examine the extent to which CMS oversees state Medicaid agencies' monitoring of the health and welfare of Medicaid beneficiaries receiving assisted living services through HCBS waiver programs, we reviewed relevant federal laws, regulations, and guidance; reviewed key documents submitted by states to CMS regarding their HCBS waiver programs; and interviewed CMS officials. We reviewed HCBS waiver programs because they are the most common type of program states use to cover assisted living services. To obtain more detailed information on CMS oversight of state monitoring, we selected a nongeneralizable sample of three states: Georgia, Nebraska, and Wisconsin. We selected these states because they were overseen by three different CMS Regional Offices and provided coverage for assisted living services to a large number of Medicaid beneficiaries using different administrative models. For these states, we reviewed documentation of CMS oversight activities, interviewed state Medicaid officials and officials in CMS's central office and the respective regional offices that have direct oversight of the states' programs and review documentation submitted by the states. We also obtained and reviewed other reports on Medicaid HCBS, including federal oversight of these services. In addition, we compared CMS's oversight process and activities to the relevant standards for internal control in the federal government.[8]

We conducted this performance audit from March 2016 to January 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[8]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 that the objectives of an entity will be achieved.

Background

Federal and state Medicaid spending on long-term care continues to increase; for example it increased from $146 billion in 2013 to $158 billion in 2015.[9] Individuals seeking long-term care generally need care that is, by definition, longer term in nature and more costly than other types of care.[10] Spending on long-term care services provided in home and community settings, including assisted living facilities, exceeds the amount spent on institutional settings such as nursing homes. State Medicaid programs may cover certain medical and non-medical services that assisted living facilities provide; however, the Medicaid statute does not provide for coverage of room and board charges of an assisted living facility.

In their federal-state partnership, both CMS and states play important roles in the oversight of Medicaid. CMS is responsible for oversight of state Medicaid programs. To conduct this oversight, CMS issues program requirements in the form of regulations and guidance, approves changes states make to their programs, provides technical assistance to states, collects and reviews required information and data from states and, in some cases, reviews individual state programs. States are responsible for the day-to-day administration of their Medicaid programs, including monitoring and oversight of the different HCBS programs through which they cover assisted living services, within broad federal rules and requirements. Each state is required to identify and designate a single state agency to administer or supervise the administration of its Medicaid program. The state Medicaid agency may partially or fully delegate the administration and oversight of the state's HCBS programs to another state agency or other entity, such as a state unit on aging, a mental health department, or other state departments or agencies with

[9]Data is for fiscal years as reported by Truven Health Analytics under subcontract with CMS. Truven notes that these figures are likely underestimated due to challenges in collecting data on long-term services provided through managed care. CMS has approved an increased number of managed long-term services and support programs in recent years—13 new programs in FY 2014 and 16 in FY 2015— as states incentivize the use of managed care to increase beneficiary access to HCBS in lieu of institutional care. See Musumeci, M., *Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers*, Kaiser Commission on Medicaid and the Uninsured: November 2014, Washington, D.C.

[10]For example, according to CMS's 2016 *Actuarial Report, a*verage spending per Medicaid beneficiary in 2015 was $7,492, while average aged beneficiary spending was $14,323 and $19,748 for persons with disabilities.

jurisdiction over a specific population or service.[11] However, the state Medicaid agency is ultimately accountable to the federal government for compliance with the HCBS requirements.

Under different authorizing provisions of federal law, states have considerable flexibility to establish multiple HCBS programs including those covering assisted living services. A state Medicaid program can have multiple HCBS programs operating under different federal authorities. CMS is responsible for ensuring that states meet the requirements associated with their HCBS programs under these different authorities.

Key to states' monitoring of the health and welfare of Medicaid beneficiaries is their tracking of, and response to, incidents that may cause harm to a beneficiary's health or welfare, such as abuse, neglect, or exploitation—commonly referred to as critical incidents.[12] Such monitoring is required for most HCBS programs; however, we previously found that requirements for states related to oversight of the health and welfare of beneficiaries in different types of HCBS programs varied, and recommended that CMS take steps to harmonize those requirements across programs.[13]

The most common HCBS programs with the most stringent federal requirements are HCBS waiver programs. These programs serve beneficiaries who are 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. CMS oversees states' HCBS waiver programs specifically by reviewing and approving applications and reviewing HCBS program reports that states submit. HCBS waiver program applications include specific requirements

[11]See 42 C.F.R. § 431.10 (2016).

[12]We previously reported that state teams provided the federal government with limited information on how often nursing home residents face actual harm or are at risk of serious injury or death. See GAO, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses,* GAO-08-517, (Washington, D.C.: May 9, 2008.)

[13]Specifically, we reported that states are not required to apply the same quality measures across HCBS programs, and noted that states using HCBS waivers to provide services have the most federal requirements. See GAO, *Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs,* GAO-17-28, (Washington D.C.: Nov. 23, 2016).

implementing various statutory and regulatory provisions. (See text box below.) One requirement is that states have the necessary safeguards in place to protect the health and welfare of beneficiaries receiving services covered by HCBS waiver programs. For each of their HCBS waiver programs, states must demonstrate to CMS that they are meeting various requirements CMS has established regarding beneficiary health and welfare.

The Six Requirements States Must Demonstrate for Home- and Community-Based Services Waiver Programs

1. Administrative authority: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
2. Level of care: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, nursing facility, or intermediate care facility.
3. Qualified providers: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
4. Service plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.
5. Health and welfare: The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
6. Financial accountability: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

Source: Centers for Medicare & Medicaid Services. | GAO -18-179

CMS also provides ongoing oversight of state HCBS programs through annual reports that states must submit for each of their HCBS waiver programs as well as renewal reports submitted about two years before an HCBS waiver is scheduled to end.[14] The state reports are intended to provide CMS with information on the operation of state HCBS waiver programs.

In contrast to long-term care services provided in nursing facilities, less is known at the federal level about the oversight and quality of care in assisted living facilities. Generally, states establish their own licensing and oversight requirements for assisted living facilities. As a result, the requirements for assisted living facilities and the type and frequency of oversight can vary across states.

In contrast, nursing homes must meet a comprehensive set of federal requirements in order to receive payment for long-term care services for Medicaid and Medicare beneficiaries in addition to state requirements.[15] CMS contracts with state entities to regularly inspect nursing facilities and investigate complaints to assess whether nursing homes meet these federal quality requirements. Annually CMS publishes a comprehensive report on nursing homes that serve Medicaid and Medicare beneficiaries, including the extent that beneficiaries are at risk for harm, based on these investigations and inspections.[16] In addition, CMS publicly reports a summary of each nursing home's quality data using a five-star quality rating based on health inspection results, staffing data, and quality measure data. The goal of this rating system is to help consumers make meaningful distinctions among high- and low-performing nursing homes.[17]

[14]The CMS-372(S) is the report state Medicaid agencies submit to CMS annually and the information submitted prior to waiver renewal we refer to as renewal reports.

[15]Medicare is the federally financed health insurance program for persons 65 years of age or over, certain individuals with disabilities, and individuals with end-stage renal disease.

[16]In 2014, CMS funded care in 15,634 nursing homes and that year about 11 percent of nursing home facilities surveyed had situations CMS identifies as placing beneficiaries in actual harm or immediate jeopardy. Among the top 10 health related deficiencies identified in nursing homes in 2014 were: deficient efforts to control infections; lack of supervision to prevent avoidable hazards in the facility; and improper management and monitoring of residents' medications. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Nursing Home Data Compendium 2015 Edition,* Washington, D.C., 2015.

[17]In December 2008, CMS enhanced its Nursing Home Compare public reporting site to include a set of quality star ratings for each nursing home that participates in Medicare or Medicaid.

This type of standardized framework for oversight, investigation and inspections, and reporting on quality of care concerns does not exist for assisted living facilities and other types of HCBS providers.

States Reported Spending $10 Billion on More than 130 Programs Covering Assisted Living Services in 2014

Forty-Eight States Reported Spending $10 Billion on Assisted Living Services for More than 330,000 Medicaid Beneficiaries in 2014; Spending per Beneficiary Varied Widely by State

Forty-eight state Medicaid agencies reported collectively spending about $10 billion in state and federal Medicaid funds for assisted living services in 2014, according to our survey. The other 3 states reported that they did not pay for assisted living services.[18] We estimate that this spending for services provided by assisted living facilities represents 12.4 percent of the $80.6 billion Medicaid spent on HCBS in all settings that year.[19] More than 330,000 Medicaid beneficiaries received assisted living services, based on data reported to us by the 48 states.[20]

Nationally, the average spending per beneficiary on assisted living services in the 48 states in 2014 was about $30,000; states provided these HCBS services through fee-for-service and managed care delivery

[18]The three states were Kentucky, Louisiana, and West Virginia.

[19] We estimated the percentage of HCBS spending that was for assisted living services by dividing the $10 billion in spending for assisted living services reported by states by the $80.6 billion Medicaid spent on HCBS as reported by the Medicaid and CHIP Payment and Access Commission. See, Home- and Community-Based Services, accessed Sept. 18, 2017. https://www.macpac.gov/subtopic/home-and-community-based-services/. The federal government matches most state expenditures for Medicaid services on the basis of a statutory formula.

[20]This is likely an underestimate because a few of the 48 states indicated that they could not give us enrollment information for all of their programs.

models.[21] Fee-for-service spending comprised 81 percent of total spending on assisted living services and managed care spending was about 19 percent of the total.[22] The cost per beneficiary reported by surveyed states also varied based on payment type; average per beneficiary cost was $31,000 for fee-for-service and $27,000 for managed care. About 21 percent of Medicaid assisted living enrollment was for beneficiaries receiving these services under a managed care delivery model. (See table 1.)

Table 1: Medicaid Spending and Enrollment for Beneficiaries Receiving Services Provided by Assisted Living Facilities, as Reported by 48 States, 2014

	Fee-for-service	Percent fee-for-service	Managed care	Percent managed care	Total
Spending[a]	$8.06 billion	81%	$1.94 billion	19%	$10 billion
Enrollment	262,645	79	70,805	21	333,450
Average spending per beneficiary	$31,000		$27,000		$30,000

Source: GAO survey of state Medicaid agencies. | GAO-18-179

[a]For purposes of the survey, we asked states to report for 2014, the amount of total Medicaid spending for services provided by assisted living facilities. Home- and community-based services may be furnished by individual providers or by assisted living facilities. We asked states to include only instances where Medicaid paid the assisted living facility directly.

Average per-beneficiary spending varied significantly across the states. For example, for the nine states with the lowest spending per beneficiary, average Medicaid spending ranged from about $1,700 to about $9,500 per beneficiary. In contrast, in the nine states with the highest per-beneficiary spending, the average spending ranged from about $43,000 to $108,000 per beneficiary.[23] (See Figure 1.) For more information on

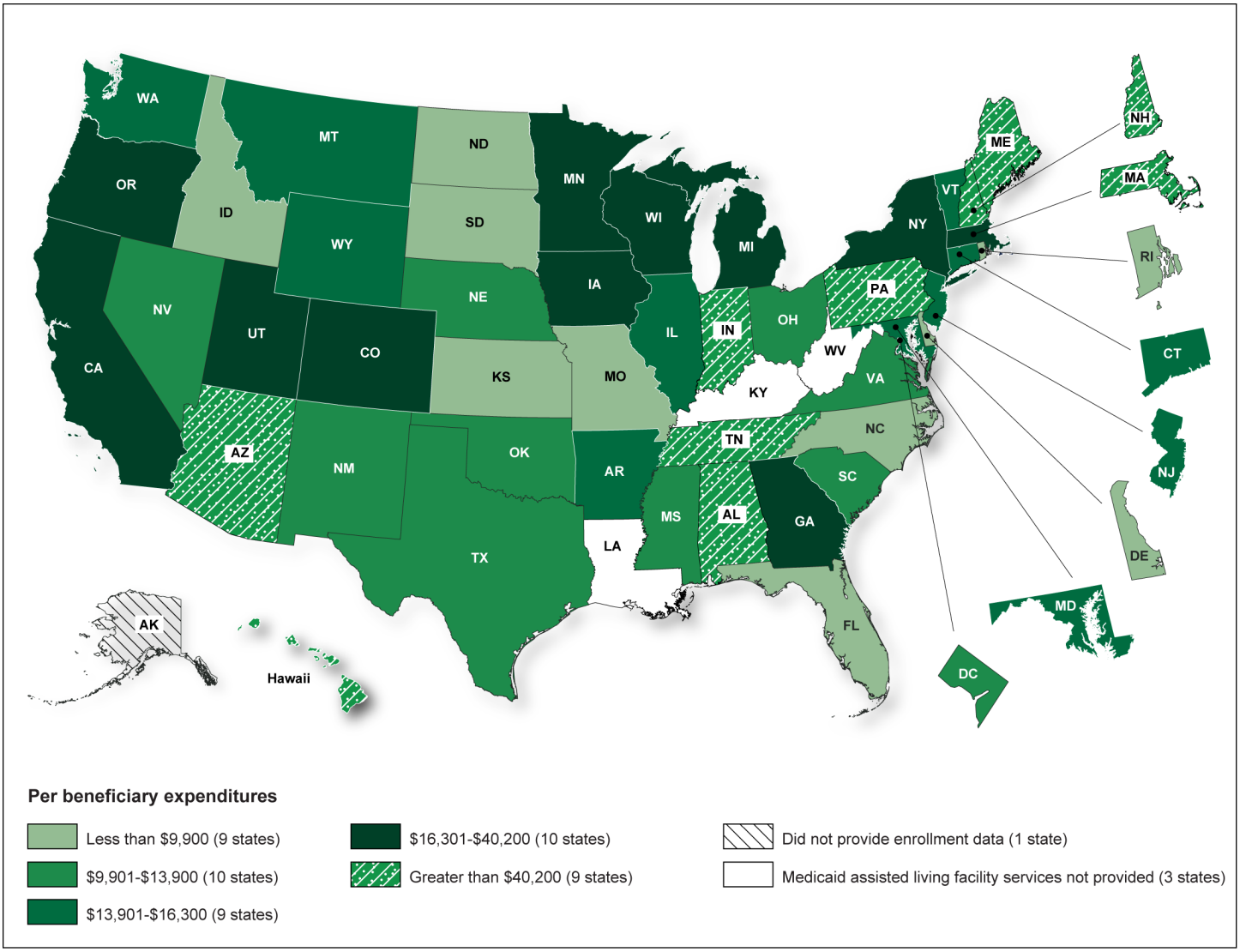
[21]Under a managed care delivery model, states pay managed care organizations a set amount per beneficiary that includes the non-federal and federal share; providers render services and then submit claims to the managed care organizations to receive payment. Under fee-for-service, states make payments directly to providers; providers render services to beneficiaries and then submit claims to the state to receive payment.

[22]The number of states using managed care to deliver long-term services and supports has increased in recent years, from 8 states in 2004 to 22 states in May 2017. Expenditures on HCBS provided under managed care have grown from about $8 billion in fiscal year 2012 to more than $19 billion in fiscal year 2015.

[23]The differences in the extent and cost of services covered may account for the differences in per beneficiary expenditures across the states. For example, the state with the lowest reported per beneficiary spending did not cover intermittent skilled nursing services or physical and occupational therapy, whereas these services were each provided in the state with the highest per beneficiary cost.

each state's enrollment, total spending, and average per beneficiary spending on assisted living services, see appendix I.

Figure 1: Average per Beneficiary Spending for Assisted Living Services by State in 2014



Source: GAO survey of state Medicaid agencies. I GAO-18-179

Forty-Eight States Administered More than 130 Programs That Covered Assisted Living Services, Mainly under HCBS Waiver Authority

The 48 states that reported covering assisted living services in 2014 said they did so through 132 different programs. The majority of the states, 31 of the 48, reported administering more than one program that covered assisted living services.[24] As illustrated in table 2 below, of the different types of HCBS programs under which states can provide coverage for assisted living services, HCBS waivers were the most common type of program they used. Specifically, 39 states and 69 percent of the programs that provided assisted living services, were operated under the HCBS waiver program. (See appendix II for additional details on each state's number of programs by program type and total number of HCBS programs that covered assisted living facility services in 2014.)

[24]Because some states had programs under more than one HCBS authority and some states had more than one program under a single HCBS authority, one state could have several different programs.

Table 2: Types of Programs 48 States Reported Using to Cover Assisted Living Services and Number of Distinct Assisted Living Service Programs, 2014

Type of Program	Number of states	Number of distinct programs (percent of programs)
Home- and Community-Based Services (HCBS) Waivers[a,b]	39	91 (69%)
1115 Demonstrations[c]	12	13 (10)
State Plan Home- and Community-Based Services[d]	3	6 (5)
Community First Choice[e]	1	2 (2)
General State Plan[f]	9	11 (8)
Other[g]	7	9 (7)
Total	**48[h]**	**132**

Source: GAO survey of state Medicaid agencies. | GAO- 18-179

[a]Section 1915(c) of the Social Security Act authorizes states to seek waivers of certain traditional Medicaid requirements to provide HCBS, including assisted living facility services. Only beneficiaries who need an institutional level of care are eligible.

[b]Section 1915(b) of the Social Security Act authorizes states to seek waivers to operate a managed care program. States may use section 1915(b) waivers to mandate enrollment in managed care in conjunction with a section 1915(c) waiver to target eligibility and provide certain HCBS.

[c]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.

[d]Section 1915(i) of the Social Security Act authorizes states to provide any of the same range of services as available under HCBS Waivers, including assisted living facility services. Unlike HCBS Waiver programs, states have the option to cover beneficiaries who need an institutional level of care, but must provide services to beneficiaries who do not require an institutional level of care.

[e]Section 1915(k) of the Social Security Act authorizes states to provide a range of HCBS services, including assisted living facility services. States must provide services to all beneficiaries who are eligible. Only beneficiaries who would otherwise need an institutional level of care are eligible.

[f]Section 1905(a) of the Social Security Act authorizes states to provide various assisted living facility services under their state Medicaid plans. States must provide services to all eligible beneficiaries and cannot limit the number covered or use waiting lists. States can provide services to beneficiaries who need or do not need an institutional level of care.

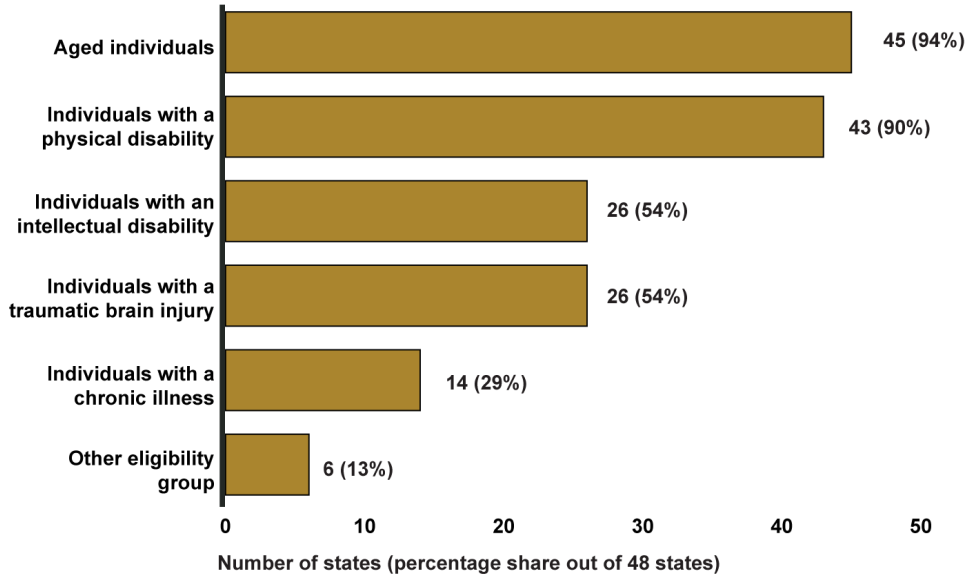
[g]An example of "other" authority is the Programs of All-Inclusive Care for the Elderly—a provider-based program that serves frail, elderly individuals with the goal of keeping them in the community rather than in long-term institutions as long as feasible.

[h]Forty-eight states responded to our survey that they covered assisted living facility services. States can use more than one program to provide assisted living services.

States Reported Offering Assisted Living Services to Certain Aged and Disabled Beneficiaries, and Most Reported Covering Common Services

Almost all of the 48 states that covered assisted living services did so for two groups of Medicaid beneficiaries eligible through their programs.[25] In 45 of 48 states, aged beneficiaries received services provided by assisted living facilities. Similarly, in 43 of 48 states, physically disabled beneficiaries received services. (See Figure 2.)

Figure 2: Medicaid Beneficiary Groups Receiving Assisted Living Services in One or More State Programs, as Reported by 48 States, 2014

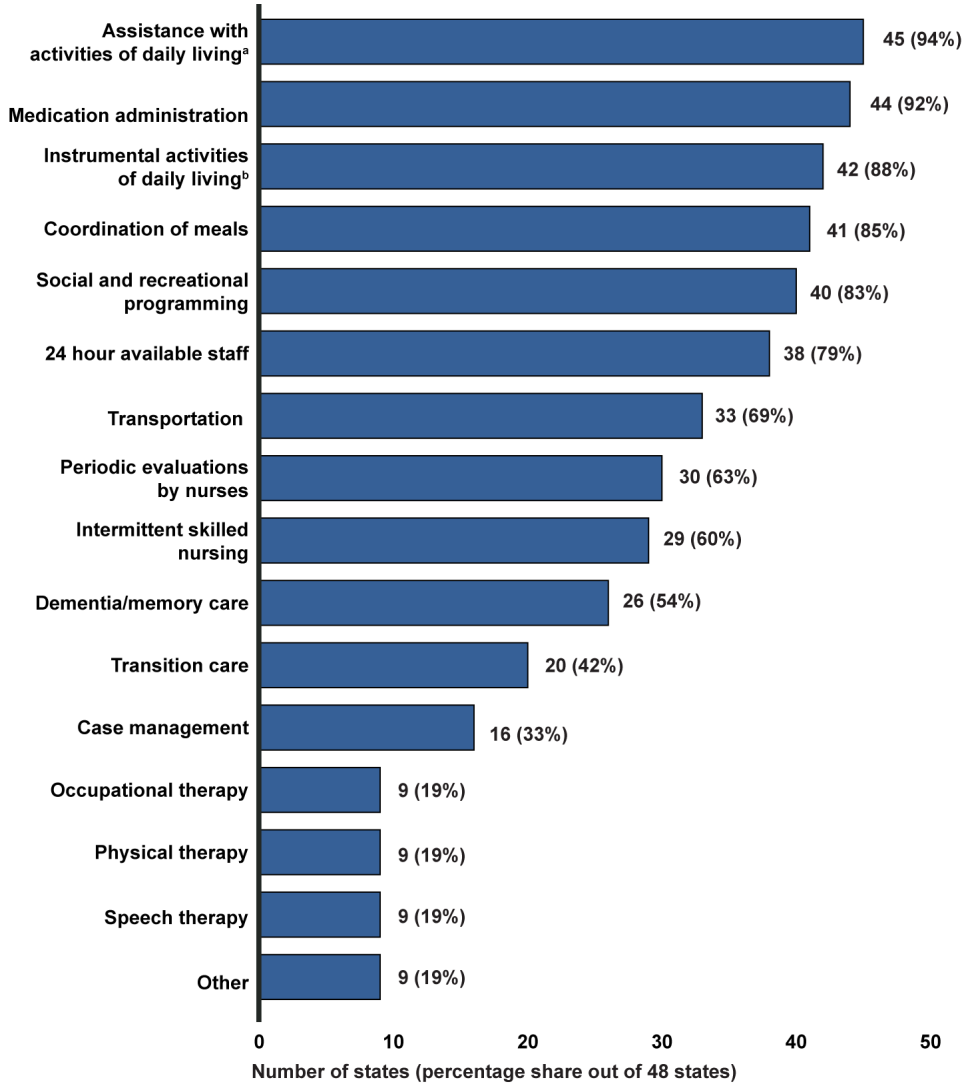


Source: GAO survey of state Medicaid agencies. I GAO-18-179

In 38 or more of the 48 states that covered assisted living services, six types of services were provided. For example, 45 states covered assistance with activities of daily living, such as bathing and dressing; 44 states covered medication administration; and 41 states covered coordination of meals. (See Figure 3.)

[25]States also provided information on challenges for Medicaid beneficiaries to access assisted living services, such as the cost of room and board. States also provided information on state programs and policies that may help address these access challenges. See appendix III for more information on access challenges states reported.

Figure 3: Types of Assisted Living Services Covered by One or More State Programs, as Reported by 48 States, 2014



Source: GAO survey of state Medicaid agencies. I GAO-18-179

[a]Activities of daily living are activities related to personal care. They include bathing, dressing, getting in and out of bed or a chair, using the toilet, and eating.

[b]Instrumental activities of daily living are activities related to independent living. They include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

State Approaches for Overseeing Health and Welfare of Beneficiaries in Assisted Living Services Varied, Including Monitoring Incidents of Beneficiary Harm

Oversight by State Medicaid Agencies Varied in the Functions Delegated to Other Agencies, the Information Used, and the Actions Taken to Correct Any Identified Problems

State Medicaid agency approaches for oversight of assisted living services varied widely in terms of who provided the oversight for their largest programs, according to their responses to our survey.[26] Thirteen of the 48 state Medicaid agencies reported delegating administrative responsibilities, including oversight of beneficiary health and welfare, to other state or local agencies. State Medicaid agencies may delegate the administration of programs to government or other agencies through a written agreement; however, state Medicaid agencies retain the ultimate oversight responsibility for those delegated functions. For example, among the 13 states that delegated HCBS program administration, the administering agencies were those that provided services to the aged, disabled, or both of these populations, such as the states' Departments of Aging.[27] (See text box, below, for examples of states' delegation.)

[26]Because states may operate multiple programs that cover assisted living services, and may administer and oversee beneficiary health and welfare differently depending on the program, we asked states to report on the oversight methods they used for their largest Medicaid program covering assisted living services. The most prevalent program, used by 30 states, was the HCBS waiver program.

[27]In our survey, we asked specifically for state Medicaid agencies to report on whether they delegated or retained administration of their largest program that included coverage of assisted living facility services.

Examples of State Medicaid Agencies' Delegation of Authority for Administration of Home- and Community-based Services' Programs Covering Assisted Living Services

Georgia's Elderly & Disabled Waiver Program was operated in 2014 by the Georgia Department of Human Services Division of Aging Services, a separate agency of the state that was not a division/unit of the Medicaid agency. The Georgia Medicaid Agency maintained a formal interagency agreement with the Division of Aging Services which describes by function the required deliverables to support compliance and a schedule for delivery of reports.

Nebraska's Waiver for Aged and Adults and Children with Disabilities is operated by the state Medicaid agency Division of Medicaid and Long Term Care. The majority of services are provided by independent contractors in order to allow service delivery in the rural and frontier areas of the state. The state Medicaid agency contracts with the Area Agencies on Aging, Independent Living Centers, and Early Development Network agencies to perform a variety of operational and administrative functions including authorizing services and monitoring the delivery of services.

Source: GAO analysis of information from selected state Medicaid agencies. | GAO-18-179

States also varied in the types of information they reported reviewing as part of the oversight of assisted living services, and the extent to which state Medicaid agencies review the information when another agency is responsible for administration.[28] For example, other entities outside the state Medicaid agency—such as the agency delegated to administer an HCBS program, or a contractor that manages provider enrollment—may check to ensure a provider is allowed to deliver services to Medicaid

[28]In our survey we asked states to indicate who, if anyone, reviewed certain information that could help identify situations that may compromise the proper care of Medicaid beneficiaries receiving services provided by assisted living facilities. Those reviewing information may include the Medicaid agency, the agency delegated to administer the program, or another entity that has a separate oversight responsibility but is not responsible for administering the program. Even though the state Medicaid agency was sometimes the administering agency, other agencies could have responsibility for reviewing certain information sources. For example in one state, the responsibility of assuring a provider was not on the Health and Human Services Office of Inspector General's list of excluded providers was contracted out, although the state's Medicaid agency was the administering agency.

beneficiaries; in such cases, however, the state Medicaid agency might not be aware of the results of such checks.

As illustrated in table 3, in all 48 states the types of information generally reviewed by either the state Medicaid agency, the agency delegated administrative responsibilities, or other agencies were: critical incident reports, the HHS Office of Inspector General's list of excluded providers, patient service plans, and information on concerns about care received directly from patients, relatives, caregivers or the assisted living facility itself. In many cases, the state Medicaid agency did not review all information sources reviewed by other agencies. For example, although all critical incident reports were reviewed in the 48 states by either the state Medicaid agency, the agency delegated administrative responsibilities, or another agency; in 16 of those states, the state Medicaid agency was not involved in those reviews, according to responses to our survey. Instead, the critical incident reports were reviewed by another entity designated responsible for the HCBS program in the state or another state entity with regulatory responsibility over the assisted living facility. Such reviews, including any critical incidents found, may not have been communicated back to the state Medicaid agency, according to responses to our survey.

Table 3: Information Sources Reviewed by State Medicaid Agencies and Other Administering Agencies as Reported by 48 States, 2014

Information reviewed	Description of information reviewed	Number of states where state Medicaid agency or other state agency reviews (%)	Number of states where state Medicaid agency does not review (%)
Critical incident reports	Generated reports of incidents of potential or actual beneficiary harm	48 (100%)	16 (33%)
Health and Human Services Office of Inspector General's list of excluded providers	List of providers excluded from participation in all Federal health care programs	48 (100)	13(27)
Patient service plans	Comprehensive care plans that identify services provided to beneficiaries based on their needs and preferences	48 (100)	18(38)
Information received directly from patient, relative, caregiver, or assisted living facility	Reports of potential beneficiary harm received from these sources	48 (100)	11 (23)
Licensing and certification results	State licensing and certification reviews of a specific assisted living facility	47 (98)	20 (43)
Complaints, grievances, and appeals	Information about the number and nature of complaints, grievances, and appeals	47 (98)	10 (21)
Inspection results	Information from state inspections of a specific assisted living facility	47 (98)	21 (45)
Information from long-term care ombudsman	Information from states' Ombudsman programs who work to resolve problems related to the health, safety, welfare and rights of individuals in long term care facilities such as assisted living	43 (90)	15 (35)
Site visits	Health and welfare Information collected from state onsite visits to an assisted living facility	46 (96)	18 (39)

Source: GAO survey of state Medicaid agencies. I GAO-18-179

State Medicaid agencies also varied in reporting the extent to which they were made aware or notified when enforcement actions were taken as a result of concerns with beneficiary care identified by other entities.[29] Various oversight actions may be taken by the state Medicaid agency, the agency delegated to administer an HCBS program, or a state regulatory agency, such as a state agency responsible for licensing and inspecting various types of HCBS providers. When delegated agencies or other licensing agencies take corrective action, the state Medicaid agency may not be aware unless notified by the agencies taking that action. For example, in 23 states, the investigation of potential incidents related to beneficiary health and welfare was delegated to another agency but in only 6 of these states was the state Medicaid agency always notified of such an investigation based on our survey. (See table 4 and text box below.)

[29]States have a variety of oversight actions available to them. In our survey we asked state Medicaid agencies to indicate what actions were available and who was responsible for carrying them out when they are informed of a situation that may compromise the care of beneficiaries receiving services in assisted living facilities. In addition, we asked when a particular action has been taken by the responsible agency, whether the state Medicaid agency was notified.

Table 4: Types of State Oversight Actions Available for Assisted Living Facilities, Delegation of Actions Outside State Medicaid Agencies, and Notification Practices, as Reported by 48 States, 2014

	Number of states	Number of states delegating action to another agency	For states that delegate action, state Medicaid agency notified when action is taken by delegated entity Number of states (percent)			
Oversight Action			Yes, always	Yes, sometimes	Never	No response
Referrals to other agencies	48	20	6 (30%)	9 (45%)	4 (20%)	1
Onsite visit	48	21	4 (19)	13 (62)	3 (14)	1
Investigation or review of incident	47	23	6 (26)	13 (57)	3 (13)	1
Corrective action plan required	46	25	9 (36)	12 (48)	3 (12)	1
Required beneficiaries to be moved from facility	46	26	17 (65)	5 (19)	3 (12)	1
Additional beneficiaries are not allowed to move into facility	43	25	15 (60)	6 (24)	3 (12)	1
Payment withheld from facility	39	12	5 (42)	3 (25)	3 (25)	1
Monetary fine/penalty to facility	36	21	11 (52)	5 (24)	4 (19)	1

Source: GAO survey of state Medicaid agencies. I GAO-18-179

Example of a Collaborative Approach to Monitoring and Ensuring Quality Care Specifically for Assisted Living Facilities

In 2009, the Wisconsin Coalition for Collaborative Excellence in Assisted Living was formed to redesign the way quality is ensured and improved for individuals residing in assisted living communities. This public/private coalition utilizes a collective impact model approach that brings together the state, the industry, the consumer, and academia to identify and implement agreed upon approaches designed to improve the outcomes of individuals living in Wisconsin assisted living communities. The core of the coalition is the implementation of an association developed, department approved, comprehensive quality assurance, quality improvement program.

Source: Wisconsin Coalition for Collaborative Excellence in Assisted Living. | GAO-18-179

State Medicaid Agencies Varied in How They Monitored Incidents of Potential or Actual Harm to Medicaid Beneficiaries Receiving Assisted Living Services

For their largest HCBS programs that covered assisted living services, the 48 states varied in how they monitored "critical incidents" that caused actual or potential harm to Medicaid beneficiaries in assisted living facilities. Specifically, the 48 states varied in their ability to report the number of critical incidents; how they defined incidents, and the extent to which they made information on such incidents readily available to the public.

These states varied in whether they could provide us the number of critical incidents involving beneficiaries for their largest programs covering assisted living services, and for those that could report, the number of incidents they reported varied widely. In 26 of the 48 states the Medicaid agencies were unable to report, for their largest program covering assisted living services, the number of critical incidents that had occurred in assisted living facilities in 2014. The remaining 22 states reported a total of 22,921 critical incidents involving Medicaid beneficiaries in their largest programs covering assisted living services.[30] The number of critical incidents reported in these states ranged from 1 to 8,900.[31] For six of these states the number of critical incidents reported was more than 1,000, (See text box, below, for examples of selected state processes managing critical incidents.)

[30]We asked states specifically to provide us with the total number of substantiated critical incidents for Medicaid beneficiaries.

[31]It was not within the scope of our review to examine why some states were able to report on substantiated critical incidents.

Selected States' Processes for Managing Beneficiary Harm or Potential Harm in Assisted Living Facilities

- **Georgia:** According to state officials in 2014 there was no centralized or comprehensive system for capturing and tracking the data on actual and potential violations. State officials acknowledged the lack of a centralized system prevents the Division of Community Health [Medicaid office] from tracking the status of each problem.
- **Nebraska:** According to state officials, Nebraska's Adult Protective Services operates an electronic system that coordinates across state social service programs. When Adult Protective Services initiates an investigation of reported harm to an assisted living resident, the state Medicaid agency is automatically notified.

Source: GAO interviews with selected state agencies. | GAO-18-179

Reasons state Medicaid agencies reported for being unable to provide us with the number of critical incidents included limitations in the data or data systems for tracking them. Nine states reported an inability to track incidents by provider type, and thus distinguish critical incidents in assisted living facilities from other providers of home and community based services. States also cited lacking a system to collect critical incidents (9 states), and that the system for reporting could not identify whether a resident was a Medicaid beneficiary (5 states). Even in the 32 states where the state Medicaid agencies reported reviewing information about critical incidents, 20 states were unable to provide the actual number of critical incidents that occurred in assisted living facilities.[32]

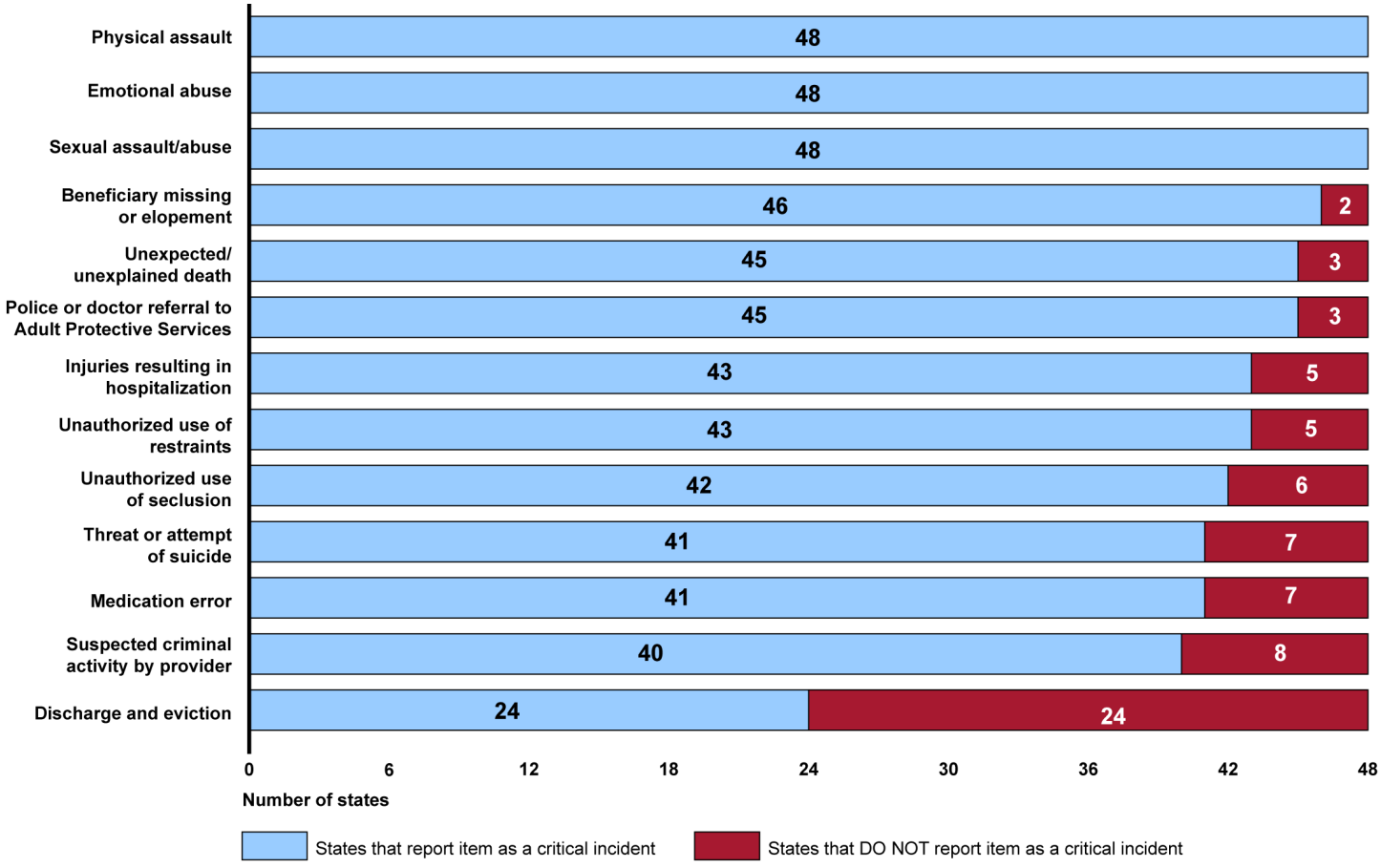
State Medicaid agencies' definitions of critical incidents also varied.[33] As illustrated in Figure 4, all 48 states cited physical assault, emotional abuse, and sexual assault or abuse as a critical incident in their largest programs providing assisted living services in 2014. However, for other types of incidents, several states did not identify the incident as critical,

[32]Critical incidents involving Medicaid beneficiaries can be reported to and investigated by entities other than state Medicaid agencies, such as Adult Protective Services for adult beneficiaries. Adult Protective Services officials are generally not located within a state's Medicaid office; as a result, Medicaid staff may not learn of incidents involving Medicaid beneficiaries that are reported directly to Adult Protective Services unless Adult Protective Services staff share this information.

[33]We asked state Medicaid agencies to identify what they considered a critical incident for their largest program. State programs within a state can vary from one program to the next in what is considered a critical incident.

including discharge and eviction from the facility (not a critical incident in 24 states), medication errors (not a critical incident in 7 states), and unauthorized use of seclusion, (not a critical incident in 6 states). For other serious incidents, a relatively small number of states did not identify the incident as critical, such as unexplained death (not a critical incident in 3 states) and missing beneficiaries (not a critical incident in 2 states). See appendix IV for a full list of the beneficiary-related incidents and the number of states that identify each as critical.

Figure 4: Selected Incidents Defined as Critical for States' Largest Medicaid Programs Providing Assisted Living Facility Services, as Reported by 48 States, 2014



Source: GAO survey of state Medicaid agencies. I GAO-18-179

Although half of the 48 states that cover assisted living services did not consider discharges or evictions to be critical incidents, according to state responses to our survey, 42 states offered certain protections related to involuntary discharge of Medicaid residents who live in assisted living facilities. The majority of protections consisted of a lease agreement requirement that applied to other housing contracts in the state, such as providing residents with eviction notices. Other protections included an appeals process (10 states) and a requirement for the facility to find an alternative location for the resident (10 states).

State Medicaid agencies also varied in whether they made information on critical incidents and other key information readily available to the public. (See table 5.) Beneficiaries seeking care in an assisted living facility may want to know the number of critical incidents related to a particular facility. Through our survey we found that states differed in the availability of information related to health and welfare that was available to the public. For example, 34 of the 48 states reported that they made critical incident information available to the public by phone, website, or in person, and the remaining 14 states did not have such information available at all. Although all 48 states had information in some form on which assisted facilities accepted Medicaid beneficiaries, 8 states could not provide this information by phone and 22 states could not provide the information in person.

Table 5: Information Publically Available about Assisted Living Facilities as Reported by 48 States, 2014

Type of Information	Available by phone, number of states (%)	Available by website, number of states (%)	Available in person, number of states (%)	Not available, number of states (%)
Which assisted living facilities accept Medicaid beneficiaries	40 (83%)	35 (73%)	26 (54%)	0 (0%)
Inspection Survey results	18 (38)	36 (75)	20 (42)	1 (2)
Complaints/grievances involving a specific facility	14 (29)	17 (35)	14 (29)	12 (25)
Critical incidents involving a specific facility	14 (29)	10 (21)	14 (29)	14 (29)
Sanctions or penalties imposed against a specific facility	14 (29)	26 (54)	16 (33)	4 (8)
Services offered at a particular facility	36 (75)	38 (79)	22 (46)	1 (2)

Source: GAO survey of state Medicaid agencies. | GAO-18-179

CMS Has Taken Steps to Improve Oversight of the Health and Welfare of Medicaid Beneficiaries in Assisted Living and Other Community Settings, but Gaps Remain

In recent years, CMS has taken steps to improve oversight of beneficiary health and welfare in HCBS programs by adding new HCBS waiver application requirements for state monitoring of beneficiary health and welfare. CMS requires state waiver applications to include specific requirements that implement various statutory and regulatory provisions, including a provision that states assure that they will safeguard the health and welfare of Medicaid beneficiaries. In March 2014, CMS added unexplained death to the events that states must be able to identify and address on an ongoing basis, as part of their efforts to prevent instances of abuse, neglect, and exploitation, and added four new requirements for states to protect beneficiary health and welfare.[34] (See table 6.) In its guidance implementing the 2014 requirements, CMS noted that state associations and state representatives' work groups had agreed that "health and welfare is one of the most important assurances to track, and requires more extensive tracking to benefit the individuals receiving services, for instance by using data to prevent future incidents." As a condition for approval of their HCBS waiver applications for each of the requirements, states must identify and agree with CMS on the type of information they will collect to provide as evidence that they will meet the requirements. However, according to CMS officials, each state Medicaid agency has wide discretion over the information it will collect and report to

[34]See Centers for Medicare & Medicaid Services, *Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers*, (Baltimore, Md.: March 12, 2014).

demonstrate that it is meeting the health and welfare requirements and protecting beneficiaries.

Table 6: CMS Requirements for States' Home- and Community-Based Waivers to Protect Beneficiary Health and Welfare, prior to and after March 2014 Guidance[a]

CMS requirements prior to March 2014	CMS requirements after March 2014
On an ongoing basis the state identifies addresses and seeks to prevent instances of abuse, neglect, and exploitation	The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare
	On an ongoing basis the state identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death
	The state demonstrates that an incident management system is in place that effectively resolves instances of abuse, neglect, exploitation, and unexplained death—critical incidents—and prevents further similar incidents to the extent possible
	The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed
	The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver

Source: GAO summary of CMS guidance. | GAO-18-179

[a]The new requirements were effective for waiver applications and waiver renewals submitted after June 1, 2014. However, states could adopt the requirements earlier.

Although CMS added the additional requirements in 2014 for safeguarding beneficiary health and welfare, the agency generally did not change requirements for how it oversees state monitoring efforts once HCBS waivers are approved. We found a number of limitations in CMS's oversight of approved HCBS waivers that undermine the agency's ability to effectively monitor state oversight of HCBS waivers. These limitations include: unclear guidance on what states should identify and report annually related to any identified program deficiencies; lack of requirements on states to regularly provide CMS information on critical incidents; and CMS's inconsistent enforcement of the requirement that states submit annual reports.

Unclear guidance on what states should identify and report annually related to any identified program deficiencies. Federal law requires states to provide CMS with information annually on an HCBS waiver's impact on (1) the type and amount, and cost of services provided and (2) the health and welfare of Medicaid beneficiaries receiving waiver services. CMS reporting requirements give states latitude to determine

what to report as health and welfare deficiencies found through state monitoring of their HCBS programs.

With respect to health and welfare, CMS's State Medicaid Manual directs states when preparing their annual reports to "check the appropriate boxes regarding the impact of the waiver on the health and welfare" of beneficiaries and to describe relevant information.[35] States are required to provide a brief description of the state process for monitoring beneficiary safeguards, use check boxes to indicate that beneficiary health and welfare safeguards have been met, and identify whether deficiencies were detected during the monitoring process. If states determine that deficiencies were identified through monitoring, states are required to "provide a summary of the significant areas where deficiencies were detected" and an explanation of the actions taken to address deficiencies and ensure the deficiencies do not recur.[36]

CMS's written instructions for completing the HCBS annual report do not provide further guidance regarding reporting of deficiencies. For example, the reporting instructions do not describe or identify 1) what states are supposed to report as deficiencies, 2) how they are to identify which deficiencies are most significant, and 3) the extent to which states need to explain the steps taken to ensure that deficiencies do not recur. The lack of clarity is inconsistent with federal internal control standards, in particular, the need for federal agencies to have processes that identify information needed to achieve objectives and address risk.[37] Without clear instructions as to what states must report, states' annual reports may not identify deficiencies with states' HCBS waiver programs that may affect the health and welfare of beneficiaries.

States may determine that issues or problems they identified through monitoring do not represent reportable deficiencies and therefore may not

[35]See U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, State Medicaid Manual, Section 2700.6.

[36]In addition to indicating whether deficiencies were found, states are also required to use check boxes to attest that "(1) all provider standards and health and welfare safeguards have been met and corrective actions have been taken where appropriate"; and (2) "all providers of waiver services were properly trained, supervised, and certified or licensed, and corrective actions have been taken where appropriate."

[37]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

report those deficiencies to CMS, increasing the risk that problems are not elevated to CMS's attention.

In the case of one of the selected states we reviewed, no problems were included on the annual reports submitted to CMS between 2011 and 2015. However, when CMS completed its review in the fourth year of the state's waiver— for purpose of renewing the waiver—it determined the state was not assuring beneficiary health and welfare. CMS found that the information the state submitted for purpose of renewal suggested a "pervasive failure" by the state to assure the health and welfare of beneficiaries receiving services, including assisted living services. In particular, CMS noted the state provided insufficient information regarding the number of unexpected or suspicious beneficiary deaths. CMS concluded that the state failed to demonstrate that it has effective systems and processes for ensuring the health and welfare of beneficiaries.

Lack of requirements on states to annually provide CMS information on critical incidents. Despite the importance of state critical incident management and reporting systems to protecting the health and welfare of beneficiaries, CMS lacks written requirements that states provide information needed for the agency oversight of state monitoring of critical incidents. According to CMS, a critical element of effective state oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents to identify needed improvements. Such a system is also consistent with federal internal controls standards which specify, in particular, the need for federal agencies to have processes that identify information needed to achieve objectives and address risk.[38]

CMS requires states to operate a critical incident reporting system. On their waiver applications states must check a box indicating they operate a system and also describe their system—including who must report and when, and what must be reported. Despite this requirement for states to have critical incident reporting systems, CMS does not require states to report to CMS any data from these systems on critical incidents as part of their required annual reports. Specifically, states are not required to include, in their annual reports, the number of critical incidents reported or

[38]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

substantiated that involve Medicaid beneficiaries. As a result, CMS does not have a method to confirm what states describe about critical incident management systems, which is a required component of states' waiver applications or to assess the capabilities of states' systems. For example, CMS cannot confirm whether the state systems can report incidents by location or type of residential provider, such as assisted living facilities; the type and severity of critical incidents that occurred; and the number of incidents that involved Medicaid beneficiaries. Without annual critical incident reporting, CMS may be at risk of (1) not having adequate evidence that states are meeting CMS requirements to have an effective critical incident management and reporting system and of (2) being unaware of problems with states' abilities to identify, track, and address critical incidents involving Medicaid beneficiaries.

Our prior work has shown that the lack of explicit reporting requirements on critical incidents not only impacts HCBS waiver programs but also impacts other types of Medicaid long-term services programs as well. Specifically,

- In a November 2016 report, we found that CMS requirements for states to report on their critical incident monitoring systems for the HCBS waiver program were more stringent than those for other types of HCBS programs, potentially leaving those other programs at even greater risk.[39] We recommended that CMS take steps to harmonize requirements across different types of HCBS programs. HHS concurred with the recommendation stating it would seek input from states, stakeholders, and the public regarding harmonizing requirements across programs.
- In an August 2017 report we found similar issues in critical incident reporting requirements for other types of long term services programs, particularly those used to provide HCBS and other long term services under managed care. We found that CMS was not always requiring states that contracted with managed care organizations to provide long term services and supports to report to CMS sufficient information on critical incidents and other key areas needed to

[39]This report focused on a review of beneficiary protections and protections to ensure that billed services were provided across different types of HCBS programs that cover personal care services. With respect to critical incidents, we found that not all types of HCBS programs required states to describe their incident management system or identify, address and seek to prevent instances of beneficiary abuse, neglect, exploitation, and unexplained death on an ongoing basis. See GAO-17-28.

monitor beneficiary access and quality.[40] We recommended that CMS take steps to identify and obtain key information needed to better oversee states' efforts to monitor beneficiary access to quality services in their managed long-term services and supports programs. HHS concurred with this recommendation and stated that the agency would take this recommendation into account as part of an ongoing review of its 2016 Medicaid managed care rule.[41]

We continue to believe that the implementation of our prior recommendations is needed to help improve CMS oversight of states monitoring of beneficiary safety.

CMS's inconsistent enforcement of the requirement that states submit annual reports. States must prepare and submit an annual report for each HCBS waiver as a condition of waiver approval. According to CMS guidance, the agency's review of the annual report is part of the ongoing oversight of HCBS waiver programs and not submitting an annual report jeopardizes the states renewal of HCBS waiver programs. However, some states have not been timely in submitting the required annual reports for their HCBS waivers. A review of 2013 HCBS annual reports by a CMS contractor, published in 2016, found that annual reports were missing for 29 HCBS waivers and multiple years' of annual reports were missing for 8 waivers.[42]

In 2014, CMS adopted new strategies to ensure compliance with HCBS waiver requirements, including the requirement that states submit annual reports on a timely basis.[43] These strategies include withholding federal funding, placing a moratorium on enrollment in the waiver, or other actions the agency determines necessary.[44] CMS officials reported that

[40] See GAO, *Medicaid Managed Care*: *CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Program*s, GAO-17-632 (Washington, D.C.: Aug. 14, 2017).

[41] In May 2016, CMS issued a final rule to modernize its Medicaid managed care regulations. See 81 Fed. Reg. 27,498 (May 6, 2016).

[42] Truven Health Analytics. Medicaid 1915(c) Waiver Data based on the CMS 372 Report, 2012 – 2013. Washington, DC. September 2016.

[43] Medicaid Program; State Plan Home and Community-Based Services,5-Year Period for Waivers, Provider Payment Reassignment, and Home- and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule, 79 Fed. Reg. 2,948, 3,020 (Jan. 16, 2014).

[44] 42 C.F.R § 441.304(g) (2016).

the agency had not used these new strategies with states that were delinquent in submitting their annual reports. Officials said they were in the process of reviewing how to implement these new strategies in the case of one state; however, as of August 2017 officials had not finalized a decision. CMS's ability to provide effective oversight of state programs and protect beneficiary health and welfare is undermined by the lack of enforcement and receipt of required annual waiver reports.

Conclusions

Effective state and federal oversight is necessary to ensure that the health and welfare of Medicaid beneficiaries receiving assisted living services are protected, especially given the particular vulnerability of many of these beneficiaries to abuse, neglect, or exploitation. CMS has taken steps to strengthen beneficiary health and welfare protections in states' HCBS waiver programs, the most common type of program that covers assisted living services and one that serves the most vulnerable beneficiaries. In particular, CMS now has multiple requirements for states to safeguard beneficiaries' health and welfare, including requirements to operate an effective critical incident management and reporting system to identify, investigate, and address incidents of beneficiary abuse, neglect, exploitation, and unexplained death.

However, CMS's ability to effectively monitor how well states are assuring beneficiary health and welfare is limited by gaps in state reporting to CMS. CMS has not provided clear guidance to states on what information to include in annual reports on deficiencies they identify. As a result, CMS lacks assurance that it is receiving consistent, complete, and relevant information on deficiencies that is needed to oversee beneficiary health and welfare. Lacking clear guidance on the reporting of deficiencies may result in a delayed recognition of problems that may affect beneficiary health and welfare. Further, for years, states have been required to check a box attesting that they operate a critical incident management system, but have not always been required to report information on incidents of potential or actual harm to beneficiaries. Given the increasing prevalence of assisted living facilities as a provider of services to Medicaid beneficiaries, it is unclear why more than half of states responding to our survey could not provide us information on the number of critical incidents that occurred in these facilities in their states. Reporting data from their critical incident systems, such as the number of incidents, the type and severity of the incidents, or the location or type of facility in which the incident occurred would provide evidence that an effective system is in place, provide information on the extent beneficiaries are subject to actual or potential harm, and allow for tracking trends over time.

Finally, CMS has not ensured that all states submit annual reports on their HCBS waiver programs as required. Without improvements to state reporting, CMS cannot ensure states are meeting their commitments to protect the health and welfare of Medicaid beneficiaries receiving assisted living services, potentially jeopardizing their care.

Recommendations for Executive Action

We are making the following three recommendations to CMS:

The Administrator of CMS should provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using HCBS waivers are required to report on their annual reports. (Recommendation 1)

The Administrator of CMS should establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred. (Recommendation 2)

The Administrator of CMS should ensure that all states submit annual reports for HCBS waivers on time as required. (Recommendation 3)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. HHS provided written comments, which are reproduced in Appendix V. The department also provided technical comments, which we incorporated as appropriate. In its written comments, the department concurred with two of our three recommendations, specifically, that CMS will clarify requirements for state reporting of program deficiencies and ensure that all states submit required annual reports on time. HHS did not explicitly agree or disagree with our third recommendation to require all states to report information on critical incidents to CMS annually. The department noted it has established a workgroup to learn more about states' health and welfare systems and that it will use the results of this workgroup to determine which additional reporting requirements would be beneficial. The workgroup's review will continue through calendar year 2018. In technical comments, HHS indicated that after the workgroup's review is complete it will consider annual reporting of critical incidents. We believe establishing the workgroup is a positive first step towards improving oversight and state reporting and encourage HHS to require annual reporting on critical incidents when developing additional reporting requirements.

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

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

Katherine M. Iritani
Director, Health Care

Appendix I: State Reported Enrollment and Spending on Assisted Living Services

Table 7: State Reported Enrollment, Total Spending, and per Beneficiary Spending for Medicaid Beneficiaries Who Received Services through Assisted Living Facilities, as Reported by 48 States, 2014

State	Number of beneficiaries receiving services in assisted living facilities	Total spending for Medicaid assisted living services[a] (in dollars)	Per beneficiary spending on Medicaid assisted living services (in dollars)
Alabama	3,278	$245,656,600	$74,941
Alaska	Not Reported	155,534,613	NA.
Arizona	9,902	422,455,160	42,664
Arkansas	1,122	18,089,168	16,122
California	28,736	1,003,608,859	34,925
Colorado	11,152	312,329,880	28,007
Connecticut	762	10,999,638	14,435
Delaware	237	1,654,537	6,981
District of Columbia	39	533,274	13,674
Florida	18,284	139,043,161	7,605
Georgia	8,093	222,302,438	27,468
Hawaii	2,418	195,478,099	80,843
Idaho	7,529	35,841,261	4,760
Illinois	9,981	147,146,560	14,743
Indiana	8,000	418,064,636	52,258
Iowa	3,449	56,557,426	16,398
Kansas	1,836	15,701,475	8,552
Maine	10,139	469,469,357	46,303
Maryland	1,507	23,192,139	15,390
Massachusetts	10,898	845,996,726	77,629
Michigan	11,731	294,453,000	25,100
Minnesota	21,847	662,035,060	30,303
Mississippi	704	9,470,956	13,453
Missouri	6,289	25,919,078	4,121
Montana	911	14,242,682	15,634
Nebraska	2,511	26,833,619	10,686
Nevada	768	7,779,845	10,130
New Hampshire	2,767	127,716,199	46,157
New Jersey	4,056	56,526,692	13,937
New Mexico	359	4,969,918	13,844
New York	7,952	160,315,655	20,160
North Carolina	18,890	179,257,515	9,490

State	Number of beneficiaries receiving services in assisted living facilities	Total spending for Medicaid assisted living services[a] (in dollars)	Per beneficiary spending on Medicaid assisted living services (in dollars)
North Dakota	7,446	12,500,572	1,679
Ohio	5,770	75,500,000	13,085
Oklahoma	238	3,076,462	12,926
Oregon	21,505	499,254,710	23,216
Pennsylvania	11,913	1,291,852,967	108,441
Rhode Island	772	6,161,768	7,982
South Carolina	13,291	132,144,812	9,942
South Dakota	1,089	7,808,825	7,171
Tennessee	6,389	465,792,989	72,905
Texas	4,341	44,545,673	10,262
Utah	1,427	24,472,823	17,150
Vermont	2,255	32,848,318	14,567
Virginia	59	584,913	9,914
Washington	16,528	253,250,000	15,322
Wisconsin	22,325	816,700,000	36,582
Wyoming	1,955	30,391,479	15,546

Source: GAO survey of state Medicaid agencies. | GAO-18-179

Note: Three states reported that they did not pay for assisted living services: Kentucky, Louisiana, and West Virginia.

[a]For purposes of the survey, we asked states to report the amount of total Medicaid spending for services provided by assisted living facilities. Home- and community-based services may be furnished by individual providers or by assisted living facilities. We asked states to include only instances where Medicaid paid the assisted living facility directly.

Appendix II: State Reported Home- and Community-Based Services (HCBS) Programs Covering Assisted Living Services

Table 8: State Reported Home- and Community-Based Programs Covering Assisted Living Services, by State and Authority, as Reported by 48 States, 2014

State	Number of programs	HCBS waiver (1915(c)(b/c))	1115 demonstrations	General state plan (1905a)	State plan HCBS (1915i)	Community first choice (1915k)	Other
Alabama	1	1	0	0	0	0	0
Alaska	4	4	0	0	0	0	0
Arizona	2	0	1	0	0	0	1
Arkansas	1	1	0	0	0	0	0
California	5	3	0	0	2	0	0
Colorado	8	7	0	1	0	0	0
Connecticut	1	1	0	0	0	0	0
Delaware	1	0	1	0	0	0	0
District of Columbia	1	1	0	0	0	0	0
Florida	6	4	1	0	0	0	1
Georgia	2	2	0	0	0	0	0
Hawaii	2	1	1	0	0	0	0
Idaho	2	1	0	1	0	0	0
Illinois	1	1	0	0	0	0	0
Indiana	7	4	0	0	3	0	0
Iowa	3	3	0	0	0	0	0
Kansas	3	1	1	0	0	0	1
Maine	5	3	0	0	0	0	2
Maryland	1	1	0	0	0	0	0
Massachusetts	8	4	1	2	0	0	1
Michigan	5	2	0	2	1	0	0
Minnesota	4	4	0	0	0	0	0
Mississippi	1	1	0	0	0	0	0
Missouri	1	0	0	1	0	0	0
Montana	1	1	0	0	0	0	0
Nebraska	2	2	0	0	0	0	0
Nevada	2	2	0	0	0	0	0
New Hampshire	3	3	0	0	0	0	0
New Jersey	1	0	1	0	0	0	0
New Mexico	1	0	1	0	0	0	0
New York	2	1	0	1	0	0	0
North Carolina	1	0	0	1	0	0	0
North Dakota	2	2	0	0	0	0	0

State	Number of programs	HCBS waiver (1915(c)(b/c))	1115 demonstrations	General state plan (1905a)	State plan HCBS (1915i)	Community first choice (1915k)	Other
Ohio	2	2	0	0	0	0	0
Oklahoma	3	3	0	0	0	0	0
Oregon	2	0	0	0	0	2	0
Pennsylvania	3	3	0	0	0	0	0
Rhode Island	2	0	2	0	0	0	0
South Carolina	5	5	0	0	0	0	0
South Dakota	1	1	0	0	0	0	0
Tennessee	4	3	1	0	0	0	0
Texas	3	2	1	0	0	0	0
Utah	1	1	0	0	0	0	0
Vermont	2	0	1	1	0	0	0
Virginia	1	1	0	0	0	0	0
Washington	5	2	0	1	0	0	2
Wisconsin	7	6	0	0	0	0	1
Wyoming	1	1	0	0	0	0	0
Total number of programs	**132**	**91**	**13**	**11**	**6**	**2**	**9**

Source: GAO survey of state Medicaid agencies. | GAO-18-179

Note: Three states reported that they did not pay for assisted living services: Kentucky, Louisiana, and West Virginia.

Appendix III: Information Regarding Medicaid Beneficiaries' Access to Assisted Living Services

Our survey of state Medicaid agencies regarding coverage, spending, enrollment, and oversight of assisted living services in 2014, obtained information on challenges for Medicaid beneficiaries to access assisted living services in their states.[1] States provided information related to factors that create challenges for Medicaid beneficiaries' ability to access and receive assisted living services and the extent states had policies to help beneficiaries with the cost of room and board.

A number of states in our survey cited common factors as creating the greatest challenges to a beneficiary's ability to access assisted living services, including

- the number of assisted living facilities willing to accept Medicaid beneficiaries (13 states or 27 percent of the 48 states)
- program enrollment caps (9 states or 19 percent of the 48 states)
- beneficiaries' inability to pay for assisted living facility room and board (9 states or 19 percent of the 48 states), which Medicaid typically does not cover
- low rates the state Medicaid program paid assisted living facilities (8 states or 17 percent of the 48 states).

A number of states reported that they had policies to assist Medicaid beneficiaries with the costs of room and board charged by assisted living facilities, which Medicaid does not typically cover.[2] Two common policies, cited by at least half of the states, were aimed at limiting how much assisted living facilities could charge Medicaid beneficiaries for room and board. For example, 30 of 48 states, limited the amount facilities could charge for room and board to the amount of income certain beneficiaries receive as Supplemental Security Income.[3] The other commonly cited policies focused on providing financial assistance to the beneficiaries to defray the room and board costs. (See table 9.)

[1]We surveyed the 50 states and the District of Columbia regarding Medicaid assisted living services in 2014. Three states responded that their Medicaid program does not cover assisted living services. Information provided is from the 48 states that reported covering assisted living services.

[2]Our survey asked states what policies, if any, they had to assist beneficiaries with paying for room and board costs of assisted living facilities.

[3]The Supplemental Security Income program provides cash payments to eligible low-income individuals with disabilities or aged.

Table 9: Policies States Used to Assist Medicaid Beneficiaries with Assisted Living Facilities' Room and Board Payments in 2014, as Reported by 48 states

Type of Policy	Description of policy	Number of states (percent)
Use Supplemental Security Income (SSI) to set payment amount	Requires assisted living facilities to accept the amount of income a beneficiary receives as SSI income as full payment for room and board[a]	30 (63%)
State or Federal funds other than Medicaid	Separate programs funded with state general funds or other Federal funds that provide financial assistance to certain beneficiaries to help defray the room and board costs	25 (52)
Establish maximum payment amount	Requires assisted living facilities to accept a maximum amount the state established for room and board for Medicaid beneficiaries	24 (50)
Funds from family or trust allowed	Allows beneficiaries to receive and use funds from family members or trusts without adversely impacting beneficiary eligibilit.	21(44)

Source: GAO survey of state Medicaid agencies. | GAO-18-179

[a]In 2015, this amount was $733, minus a state-designated personal needs allowance.

Appendix IV: Events That States Defined as Critical Incidents

Table 10: Events That States Defined as Critical Incidents

Event	Yes a critical incident Number of states (percentage)	Not a critical incident Number of states (percentage)
Physical assault	48 (100.0%)	0 (0.0%)
Emotional abuse	48 (100.0)	0 (0.0)
Neglect	48 (100.0)	0 (0.0)
Sexual assault/abuse	48 (100.0)	0 (0.0)
Financial exploitation	47 (97.9)	1 (2.1)
Beneficiary missing/elopement	46 (95.8)	2 (4.2)
Unexpected/unexplained death	45 (93.8)	3 (6.3)
Police or doctor referral to Adult Protective Services	45 (93.8)	3 (6.3)
Injuries resulting in hospitalization	43 (89.6)	5 (10.4)
Unauthorized use of restraints	43 (89.6)	5 (10.4)
Unauthorized use of seclusion	42 (87.5)	6 (12.5)
Threat or attempt of suicide	41 (85.4)	7 (14.6)
Medication error	41 (85.4)	7 (14.6)
Suspected criminal activity by provider	40 (83.3)	8 (16.7)
Injuries needing medical attention, but not hospitalization	36 (75.0)	12 (25.0)
Natural disaster	34 (70.8)	14 (29.2)
Physical infrastructure issue	30 (62.5)	18 (37.5)
Discharge and eviction	24 (50.0)	24 (50.0)
Minor injuries not requiring medical attention	17 (35.4)	31 (64.6)

Source: GAO survey of state Medicaid agencies. | GAO-18-179

Note: Three states reported that they did not pay for assisted living services: Kentucky, Louisiana, and West Virginia.

Appendix V: 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

DEC 12 2017

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

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed*" (GAO-18-179).

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

Sincerely,

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 ASSISTED LIVING SERVICES: IMPROVED FEDERAL OVERSIGHT OF BENEFICIARY HEALTH AND WELFARE IS NEEDED (GAO-18-179)

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[1] that set forth requirements for several Medicaid authorities under which states may provide home and community-based assisted living support. The regulation was designed to enhance the quality of home and community-based services and provided additional protections to individuals who receive services under these Medicaid authorities. In particular, as part of the 1915(c) waiver approval process, each waiver must have its own Health and Welfare Assurance system wherein the state demonstrates that it has designed and implemented an effective system for assuring waiver participant health and welfare. As part of this system, HHS requires states to develop and measure performance indicators in fourteen areas, which are reported to HHS in the form of an annual report. In addition, the annual report to HHS must include a mandatory quality improvement project/remediation when the compliance threshold for a performance measure is below 86 percent[2].

To assist with implementation of home and community-based services, HHS offers technical assistance resources to states to improve quality under home and community-based services programs. This includes a 2014 Informational Bulletin that modifies the quality assurance systems under 1915(c) waivers to strengthen the oversight of beneficiary health and welfare reporting requirements[3]. Specifically, this guidance modified HHS requirements regarding reporting on individual remediation, requiring states to report on individual activities related to instances of substantiated abuse, neglect and/or exploitation. Furthermore, in January 2015, HHS updated a 1915(c) technical guide, which outlines HHS' expectations on what states need to include in their waiver application with regard to reporting and investigating critical events or incidents.

Lastly, HHS provides monthly webinars to states on a variety of home and community-based services topics. For example, in January 2017, HHS conducted a webinar to assist states in creating and implementing quality and performance measures across the home and community based services waiver authorities, including a focus on remediation reporting requirements.

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

[1] 79 FR 2948
[2] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf
[3] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID ASSISTED LIVING SERVICES: IMPROVED FEDERAL OVERSIGHT OF BENEFICIARY HEALTH AND WELFARE IS NEEDED (GAO-18-179)

GAO Recommendation
The Administrator of the Centers for Medicare and Medicaid Services (CMS) should provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using HCBS waivers are required to report on their annual reports

HHS Response
HHS concurs with this recommendation. HHS will consider additional guidance to clarify requirements regarding the monitoring and reporting of deficiencies that states using home and community based service waivers are required to report in their annual reports.

GAO Recommendation
The Administrator of CMS should establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, including, at a minimum, the type of critical incidences involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred.

HHS Response
HHS currently requires states to report on all substantiated instances of abuse, neglect, or exploitation every three years. In addition, states are required to report annual information on their waiver's impact on the type, amount, and cost of services provided as well as the health and welfare of beneficiaries[4]. In an effort to improve this process, HHS has established a workgroup with selected states and has utilized a contractor to help understand different states' health and welfare oversight systems. HHS will use the results of this workgroup to determine which additional reporting requirements would be beneficial. This work is currently underway and is expected to continue through calendar year 2018 and includes promising practices in performance measures developed for consideration by the states.

GAO Recommendation
The Administrator of CMS should ensure that all states submit annual reports for HCBS waivers on time as required.

HHS Response
HHS concurs with this recommendation. HHS will work with states to ensure that all annual reports for home and community based service waivers are submitted on time as required.

[4] 42 CFR 441.302(h)

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Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Tim Bushfield and Christine Brudevold (Assistant Directors), Jennie Apter, Shirin Hormozi, Anne Hopewell, Kelsey Kreider, Perry Parsons, Vikki Porter, and Jennifer Whitworth made key contributions to this report.