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CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services

GAO Highlights

Highlights of [GAO-17-169](#), a report to congressional requesters.

Why GAO Did This Study

A growing share of long-term care spending under Medicaid, a joint federal-state health care program, is for services provided in home and community settings. Medicaid spending on these services—about \$80 billion in 2014—now exceeds spending on institutional long term care. Personal care services are key components of long-term, in-home care, providing assistance with basic activities, such as bathing, dressing, and toileting, to millions of individuals seeking to retain their independence and to age in place. However, these services are also at high risk for improper payments, including fraud.

Given the expected increase in the demand for and spending on personal care services and risk of improper payments, GAO was asked to examine available data on personal care services and CMS's use of the data. This report: (1) describes the CMS systems that collect data on personal care services and what the data reveal, and (2) examines the extent to which data from these systems can be used for oversight. GAO reviewed information from two CMS data systems, reviewed relevant federal guidance and documents, and interviewed officials and researchers.

What GAO Recommends

GAO recommends that CMS improve personal care services data by: establishing standard reporting guidance for key data; ensuring linkage between data on the provision of services and reported expenditures; ensuring state compliance with reporting requirements; and developing plans to use data for oversight.

View [GAO-17-169](#). For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

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What GAO Found

Two data systems managed by the Centers for Medicare & Medicaid Services (CMS)—the federal agency that oversees Medicaid—collect information from states on the provision of and spending on personal care services:

- The Medicaid Statistical Information System (MSIS) collects detailed information from provider claims on services rendered to individual Medicaid beneficiaries and state payments for these services.
- The Medicaid Budget and Expenditure System (MBES) collects states' total aggregate Medicaid expenditures across 80 broad service categories.

Information from these two CMS data systems can be used in the aggregate to describe broadly the provision of and spending on Medicaid personal care services. For example, MBES data show that total fee-for-service spending on these services was at least \$15 billion in 2015—up \$2.3 billion from 2012.

However, the usefulness of the data collected from these two systems for CMS oversight is limited because of data gaps and errors. To provide effective oversight, including decision making, external reporting, and monitoring program operations, CMS needs timely, relevant and reliable data on personal care services rendered and the amount paid. GAO found that the data collected did not always meet these standards. For example:

- MSIS data were not timely, complete, or consistent. The most recent data available at the time of GAO's audit were for 2012 and only included data for 35 states. Further, 15 percent of claims lacked provider identification numbers, over 400 different procedure codes were used to identify the services, and the quantity and time periods varied widely. Without good data, CMS is unable to effectively monitor who is providing personal care services or the type, amount, and dates of services. CMS may also face challenges determining whether beneficiaries were eligible for services and assessing the reasonableness of the amount of services claimed.
- MBES data were not always accurate or complete. From 2012 through 2015, GAO found that 17 percent of expenditure lines were not reported correctly. Nearly two-thirds of these errors were due to states not separately identifying personal care services expenditures, as required by CMS. Inaccurate and incomplete reporting limits CMS's ability to ensure federal matching funds are provided consistent with states' approved programs.

CMS is developing a new Medicaid claims system to replace MSIS and recently established a new office to support CMS's use of Medicaid data for program management and monitoring. However, CMS has not issued guidance related to reporting of personal care services that addresses the gaps GAO identified, or developed plans to use the data for oversight purposes. Without improved data and plans for how it can be used for oversight, CMS could continue to lack critical information on personal care service expenditures.

HHS agreed with two of GAO's recommendations to ensure state compliance with reporting requirements and develop plans to use the data. HHS neither agreed nor disagreed with two others.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HCBS	Home- and community-based services
HHS	U.S. Department of Health and Human Services
MBES	Medicaid Budget and Expenditure System
MSIS	Medicaid Statistical Information System
OIG	Office of Inspector General

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January 12, 2017

The Honorable Thomas R. Carper
United States Senate

The Honorable Claire McCaskill
United States Senate

The Honorable Fred Upton
House of Representatives

Medicaid, a federal-state health financing program for low-income and medically needy individuals, is the nation’s primary payer of long-term care services and supports for disabled and aged individuals. Medicaid spending on long-term care services and supports is significant, representing more than one-quarter of Medicaid spending annually.¹ Historically, Medicaid spending for long-term care has been largely for services provided in institutional settings, such as nursing homes. In recent years, this trend has changed, and the majority of federal and state spending has shifted towards home- and community-based services (HCBS)—that is, services and assistance provided to beneficiaries in their homes or other settings integrated with their communities.² Personal care services are a significant component of HCBS. Personal care services provide assistance to beneficiaries of all ages who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities. Personal care services assist beneficiaries with activities of daily living such as bathing, dressing, and toileting. Such assistance can

¹This amount represents spending on a fee-for-service basis and excludes spending on long-term services and supports provided through managed care organizations. See U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid*, (Washington, D.C.: 2016). Under a fee-for-service delivery model, state Medicaid programs make payments directly to providers who render services to beneficiaries. Under a managed care delivery model, states typically contract with managed care organizations to provide a specific set of Medicaid-covered services to beneficiaries; states pay the managed care organizations a set amount per beneficiary per month to provide those services.

²See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports in FY 2013*, (June 30, 2015).

enable disabled and aged beneficiaries to remain in their homes, maintain their independence, and participate in community life to the fullest extent possible.

The federal cost of Medicaid long-term care spending is expected to increase from \$75 billion in 2015 to \$111 billion in 2026.³ The demand for personal care services is expected to increase as result of the aging of the nation's population and increased opportunities for the aged and disabled to live in their homes instead of institutions. The increased Medicaid spending on HCBS may also increase the risk of Medicaid making improper payments for personal care services.⁴ In 2014, the most recent data available, an estimated 6 percent of all payments for personal care services were improper, and the projected dollar amount of payment errors was over \$2 billion, the third-highest of all Medicaid services.⁵ Despite the expected increase in spending and the risk of improper payments for personal care services, the extent to which CMS data systems specifically identify information about personal care services is not well understood.

Under broad federal requirements, states administer their individual Medicaid programs under the oversight of the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS). For example, states determine which optional services to cover, set payments rates that different providers will receive for various covered services, and pay providers for claims submitted for services rendered. The provision of most HCBS, including personal care

³Congressional Budget Office, *Detail of Spending and Enrollment for Medicaid for CBO's March 2016 Baseline*, (Washington, D.C.: 2016).

⁴An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note). Additionally, Office of Management and Budget guidance instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

⁵Centers for Medicare & Medicaid Services (CMS), *Medicaid and CHIP 2014 Improper Payments Report*, (Washington, D.C.: 2015).

services, is an optional Medicaid benefit that states may provide, and every state has at least one program to provide HCBS, including personal care services. Federal law allows states to establish and provide personal care services under several different statutory authorities; as a result, states may have several different programs that provide personal care services. CMS has an important responsibility to ensure states report Medicaid expenditures correctly, identify payments at risk for improper payments to target resources, and provide technical assistance and support to states to ensure they have data and oversight tools to identify questionable payments and reduce improper payments, including and fraud and abuse.

In light of the expected increase in demand for personal care services, the vulnerability of Medicaid beneficiaries receiving these services, the variety of state programs, and the high rate of improper payments, you asked about the federal data that CMS collects on Medicaid personal care services and CMS's use of these data to oversee state programs. This report:

- describes the CMS systems that collect data on Medicaid personal care services and what the data reveal about the provision of and spending on these services; and
- examines the extent to which data CMS collects from these systems can be used to monitor the provision of and spending on personal care services by state Medicaid programs.

To describe the CMS systems that collect data on Medicaid personal care services and what the data reveal about the provision of and spending on these services, we reviewed and analyzed the most recently available data from two CMS data systems. These systems collect (1) detailed records on the services rendered to Medicaid beneficiaries, and (2) states' aggregate Medicaid expenditures by broad categories of service. For the system that collects information on services rendered, referred to as the Medicaid Statistical Information System, we analyzed data for calendar year 2012—the latest available data at the time of our review—

for the 35 states that had finalized 2012 data.⁶ We examined all records of Medicaid services that were either associated with a known personal care services procedure code or were categorized as personal care services in a record's more generic "type of service" field. We analyzed these data across various categories, such as eligibility groups (i.e., children ages 0-18, adults ages 19-64, aged individuals ages 65 and older, and disabled individuals of all ages) and delivery model (i.e., fee-for-service or managed care).⁷ For the system that collects states' Medicaid expenditures, referred to as the Medicaid Budget and Expenditure System (MBES), we analyzed data for all 50 states and Washington, D.C., for calendar years 2012 through 2015, a time period that allowed for examining trends.⁸ We examined each of the expenditure reporting lines for which personal care services were separately reported. We also reviewed relevant guidance and documentation, including laws, regulations, and CMS data forms and data dictionaries; obtained reports issued by CMS, the HHS Office of Inspector General (OIG), and other researchers related to the information CMS collects about Medicaid HCBS and personal care services; and we interviewed CMS officials and other experts familiar with the data systems. On the basis of these steps, we determined that data reported by states were sufficiently reliable for

⁶The 35 states are: Alaska, Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, North Carolina, Nebraska, New Jersey, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Vermont, Washington, West Virginia, and Wyoming. We did not use more recent data because of the large number of states (16) for which final data were unavailable at the time we began our analysis. The 16 excluded states are Arizona, California, Colorado, District of Columbia, Hawaii, Idaho, Kansas, Louisiana, Maine, Massachusetts, New Hampshire, New Mexico, North Dakota, Rhode Island, Utah, and Wisconsin.

⁷Individuals may be eligible for Medicaid under multiple criteria. CMS's claims data indicate which of several options are associated with each beneficiary, which we condense into the four general groups for analysis: Children (age 0-18), adults (age 19 through 64), aged (age 65 and older), or "disabled," which may categorize individuals of any age with physical, developmental, or intellectual conditions that limit their abilities. A disabled categorization in the claims data indicates that the individual is eligible for Supplemental Security Income, a federal program designed to help aged, blind, and disabled people who have little or no income. In most states, if you are a beneficiary of this program, you may be automatically eligible for Medicaid.

⁸In this report, we use the term state to refer to the 50 states and the District of Columbia. We did not include claims and expenditure data from Puerto Rico or the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, or the U.S. Virgin Islands.

purposes of reporting summary-level information on personal care services, such as aggregate state-reported spending on personal care services. However, we also identified reporting errors and data issues that limit the use of the data for other oversight purposes. We report on these errors and limitations, and their implications in objective 2 of this report.

To examine the extent to which data CMS collects from these systems can be used to monitor the provision of and spending on personal care services, we interviewed CMS officials about the data they use to monitor states' Medicaid personal care services programs, including the data systems we examined for the first objective. We also interviewed CMS officials about how they assess the completeness and accuracy of the data. We assessed the reliability of the data by screening for missing data, outliers, and obvious errors, and compared reported information with information from CMS regarding the different types of programs under which the states provide personal care services. In addition, we reviewed the relevant standards for internal control in the federal government.⁹ We determined that the data were sufficiently reliable for purposes of assessing CMS's use of the data to monitor the provision of and spending on personal care services, and report on limitations and errors that we found when examining the data.

We conducted this performance audit from July 2015 to January 2017 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 finding and conclusions based on our audit objectives.

⁹See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999) and [GAO-14-704G](#) (Washington, D.C.: September 2014). Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

Background

Medicaid Program Overview

Medicaid is jointly financed by the federal government and the states, with the federal government matching most state Medicaid expenditures using a statutory formula that determines a federal matching rate for each state.¹⁰ Medicaid is a significant component of federal and state budgets, with estimated total outlays of \$554 billion in fiscal year 2015, of which \$347 billion is expected to be financed by the federal government and \$207 billion by the states.¹¹ An important health care safety net, Medicaid served about 78 million individuals during fiscal year 2014.¹² There are multiple ways to be eligible for Medicaid that relate to an individual's age, income, and disability status.

As a federal-state partnership, both the federal government and the states play important roles in ensuring that Medicaid is fiscally sustainable over time and effective in meeting the needs of the vulnerable populations it serves. States administer their Medicaid programs within broad federal rules and according to individual state plans approved by CMS, the federal agency that oversees Medicaid. States can also seek permission from CMS to provide services under waivers of traditional Medicaid requirements, for example to provide services to a segment of the state's eligible population.

¹⁰The federal government and states share in the financing of Medicaid expenditures, with the federal government matching most state expenditures for services on the basis of a statutory formula called the Federal Medical Assistance Percentage (FMAP). Federal law specifies that the regular FMAP will be no lower than 50 percent and no higher than 83 percent. For fiscal year 2015, regular FMAP rates ranged from 50.00 percent to 73.58 percent. For certain Medicaid enrollees, states receive a higher federal match based on whether the state expanded Medicaid, as provided for under the Patient Protection and Affordability Act.

¹¹Expenditure data are from U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid* (2016).

¹²Enrollment data are from Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book* (Washington, D.C.: 2015). This figure represents the total number of individuals ever enrolled in the program in fiscal year 2014. There were about 64 million individuals enrolled in the program at any one point in time in fiscal year 2014.

Federal Medicaid Funds and State Medicaid Payments

To obtain federal matching funds for Medicaid payments to providers, states submit their estimated Medicaid expenditures—their payments for covered services and costs of administering the program—to CMS each quarter for the upcoming quarter. After CMS has approved the estimated expenditures, it makes federal matching funds available to the state for the purpose of making Medicaid payments during the quarter. States typically finance Medicaid payments to providers with a combination of federal funds advanced to them and nonfederal funds (e.g., funds from state and local government sources).¹³

Federal matching funds are available to states for different types of payments that states make, including payments made directly to providers for services rendered and payments made to managed care organizations. Under a fee-for-service delivery model, states make payments directly to providers; providers render services to beneficiaries and then submit claims to the state to receive payment. States review and process fee-for-service claims and pay providers based on state-established payment rates for the services provided. Under a managed care delivery model, states pay managed care organizations a set amount per beneficiary; providers render services to beneficiaries and then submit claims to the managed care organization to receive payment. Managed care plans are required to report to the states information on services utilized by Medicaid beneficiaries enrolled in their plans—information typically referred to as encounter data. Most states use both fee-for-service and managed care delivery models, although the number of beneficiaries served through managed care has grown.

Federal law requires each state to operate a mechanized claims processing system to process and record information about the services provided under both fee-for-service and managed care delivery models. Provider claims and managed care encounters are required to include information about the service provided, including the general type of service; a procedure code that identifies the specific service provided; the location of the service; the date the service was provided; and information

¹³States finance the nonfederal share of their Medicaid programs in large part with state general funds, but they also depend on other sources of funds—such as state taxes on health care providers and funds from local governments—to finance the remainder. Up to 60 percent of the nonfederal share of payments may be financed with local sources of funds.

about the provider who rendered the service. For services delivered under a fee-for-service delivery model, the claims record must also include the payment amount. Federal law requires states to collect managed care encounter data, but actual payment amounts to individual providers are not required.

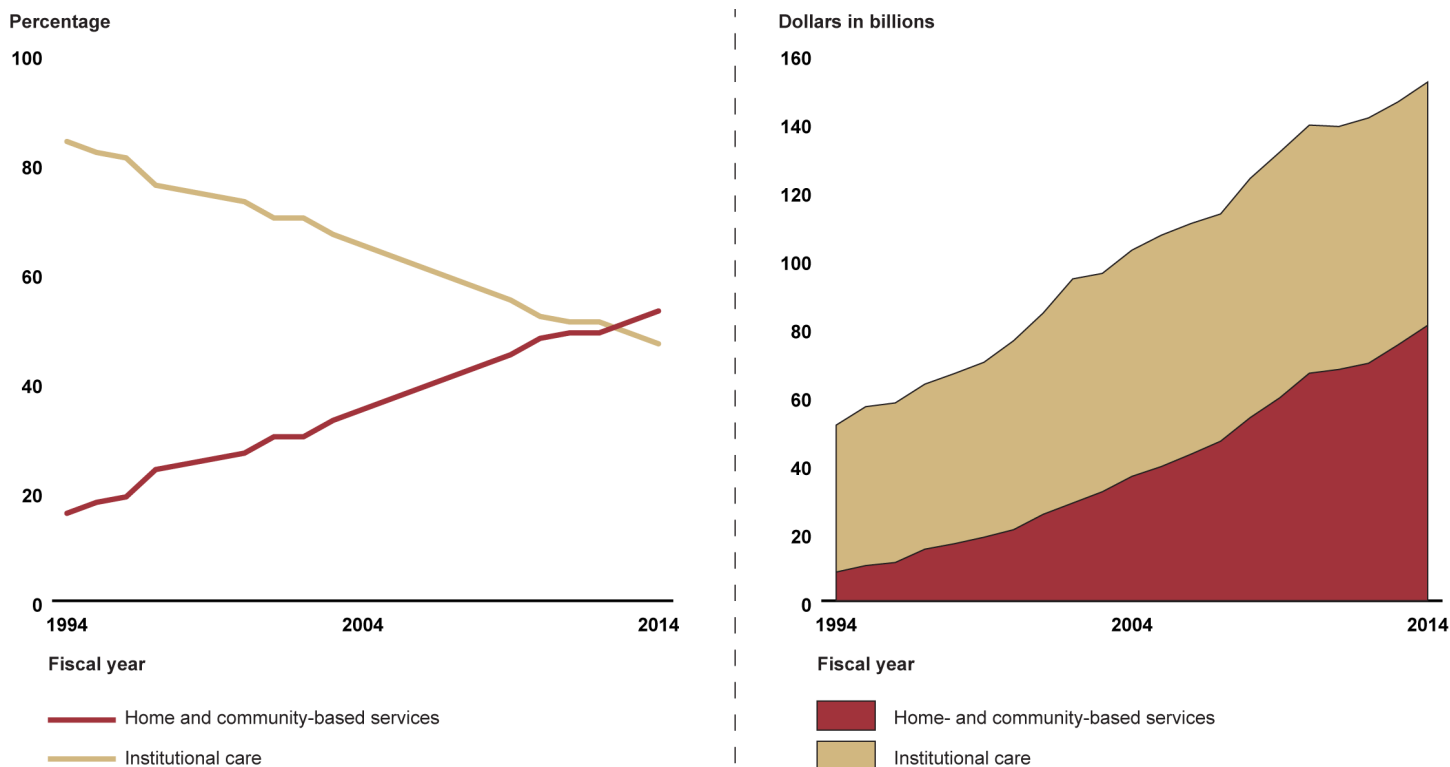
Medicaid Long-term Services and Supports

Home- and community-based services, which include personal care services, are a component of a larger class of health and health-related services and nonmedical supports for individuals of all ages who need care for an extended period of time, broadly referred to as long-term services and supports. Long-term services and supports financed by Medicaid are generally provided in two settings: institutional facilities, such as nursing homes and intermediate-care facilities for individuals with intellectual disabilities; and home and community settings, such as individuals' homes or assisted living facilities. Under Medicaid requirements governing the provision of services, states generally must provide institutional care to Medicaid beneficiaries, while HCBS coverage is generally an optional service. Medicaid spending on long-term services and supports provided in home and community settings has increased dramatically over time—to about \$80 billion in 2014—while the share of spending for care in institutions has declined, and HCBS spending now exceeds long-term care spending for individuals in institutions (see fig. 1).¹⁴ All 50 states and the District of Columbia provide long-term care

¹⁴Medicaid HCBS and institutional long-term care spending is roughly equal for services provided on a fee-for-service basis. However, when long-term care services provided under a managed care arrangement are included, HCBS spending exceeds institutional spending. Truven Health Analytics, under contract with CMS, reported that 2013 was the first instance of expenditures for HCBS exceeding institutional services as a percentage of all long-term care services—51 percent for HCBS compared to 49 percent for institutional services. See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports in FY 2013*, (June 30, 2015)

services to some Medicaid beneficiaries in home and community settings.¹⁵

Figure 1: Percentage of Spending, and Total Spending on, Medicaid Long-Term Services and Supports for Institutional Care and Home- and Community-Based Services, Fiscal Years 1994 through 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) and state data collected and published by Truven Health Analytics, under contract with CMS. | GAO-17-169

Note: Data are for the 50 States and the District of Columbia.

Personal care services are a key component of long-term services and supports and include assistance with activities of daily living, such as

¹⁵Changes to federal Medicaid law in the last 35 years have expanded states' options for providing long-term care services and supports, including personal care services, in home and community settings. Factors driving these changes may include the desire and increased ability of beneficiaries who are aged and disabled to live in their homes and communities and the Supreme Court's 1999 *Olmstead* decision, which held that states must serve individuals with disabilities in community-based settings under certain circumstances. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

bathing and dressing, and in some cases instrumental activities of daily living, such as preparing meals and housekeeping. Personal care services are typically nonmedical services provided by personal care attendants—home-care workers who may or may not have specialized training. Personal care attendants may be employed by a provider agency or self-employed. In some cases, they are friends or family members of the beneficiary and, under certain types of Medicaid PCS programs, can be spouses, parents, or other legally responsible relatives. Under what is known as an agency-directed model, a provider agency employs multiple attendants. The provider agency hires, fires, pays, and trains the attendant to provide personal care services to Medicaid beneficiaries. Under a participant-directed model, beneficiaries or their representatives have the authority to manage personal care services by selecting, hiring, firing, and training attendants themselves and have a greater say in the personal care services the beneficiary receives. Overall, the number of personal care attendants employed is projected to increase by 26 percent from 2014 to 2024.¹⁶

As we recently reported, states have considerable flexibility to establish Medicaid personal care services programs under different provisions of federal law that authorize different types of programs.¹⁷ States may provide personal care services under a Medicaid state plan, a state plan amendment, or a waiver, such as the 1915(c) waiver, referred to as an HCBS Waiver—the most common type of program through which states provide personal care services. Section 1915(c) authorizes states with HHS approval to waive certain traditional Medicaid requirements, allowing states to target services to specific groups and limit the number of

¹⁶Specifically, the number of attendants is estimated to grow from 1,768,400 in 2014 to 2,226,500 in 2024. The 26 percent rate of growth is much faster than the projected national average for all occupations of 7 percent. See U.S. Department of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2016-17 Edition* (2016).

¹⁷See GAO, *Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs*, GAO-17-28 (Washington, D.C.: Nov. 23, 2016).

beneficiaries served.¹⁸ Program options available under a Medicaid state plan or amendment include State Plan Personal Care Services, State Plan HCBS, and Community First Choice. Individual states can and do have multiple programs operating under different authorities. Some requirements, such as cost neutrality and maintenance of expenditures, are applicable only to specific program options.¹⁹ In addition, under Community First Choice programs, states receive a 6 percentage point increase in their federal matching rate for personal care and other home- and community-based services.

The nature of HCBS can complicate both federal and state oversight, including understanding the time frames in which services were delivered, the types of services delivered, and the providers delivering services billed to and paid for by Medicaid. According to numerous HHS OIG reviews and CMS's annual review of Medicaid improper payments, the provision of Medicaid personal care services is at high risk for improper payments. For example:

- In 2012, the OIG issued a report synthesizing results from 23 individual reviews of states' programs conducted over a 6-year timeframe between 2006 and 2012. Then, in October 2016, it issued an investigative advisory to CMS regarding Medicaid personal care services based on more than 200 investigations opened since the

¹⁸CMS maintains a system, called the Waiver Management System, that collects annual state reports for services provided under a HCBS Waiver. Information states submit, using standard form CMS-372, includes the number of participants who used, and the amount spent, for each type of waiver service. According to CMS officials, the Waiver Management System does not generate a database for analysis purposes, and we therefore exclude it from the scope of this report; however, summary reports that compile information from states' CMS-372s are available on CMS's website.

¹⁹Federal law requires state HCBS Waiver programs be cost neutral—that is, states must show that the average Medicaid expenditures for services provided under a waiver are equal to or less than the average for the same population to be served in an institution. See 42 U.S.C. § 1396n(c)(2)(D). States offering HCBS under Community First Choice are subject to a maintenance of expenditures requirement—specifically, for the first full fiscal year the option is implemented, participating states must maintain or exceed the preceding year's level of expenditures for services provided to disabled and elderly beneficiaries. See 42 U.S.C. § 1396n(k)(3)(c).

2012 report.²⁰ The HHS OIG concluded that existing controls and safeguards intended to prevent improper payments in the Medicaid program and to ensure patient safety and quality of care were often ineffective. Problems the HHS OIG found included: lack of details on personal care services claims, including missing dates for when services were provided and lack of information identifying the provider of services; lack of evidence that services were rendered; and lack of prepayment controls to prevent payments for home-based personal care services when a beneficiary is in an institution. The HHS OIG also noted that federal and state Medicaid investigations have found an increasing volume of fraud involving personal care attendants. Of particular concern were personal care services provided under the Participant-Directed Option, where the beneficiary has direct responsibility over the care they receive and a budget to pay personal care attendants. These findings highlight the need to have better information about the identity of the individuals providing personal care services.

- CMS reported for 2014 that Medicaid personal care services accounted for an estimated \$2.2 billion in improper fee-for-service payments and had the third-highest improper payment rate of the major categories of service, estimated at 6.3 percent.²¹ Factors that CMS found contributed to improper personal care services payments included a lack of documentation verifying that beneficiaries received services; a lack of documentation of the specific services provided; and missing or incorrect documentation on the amount, or units, of services provided.

²⁰See Department of Health and Human Services, Office of the Inspector General, *Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement* (Washington, D.C.: Nov. 2012) and Department of Health and Human Services, Office of the Inspector General, *Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services* (Washington, D.C.: Oct. 2016). Investigative advisories are issued in cases where systemic weaknesses or management problems are identified during an investigation.

²¹Centers for Medicare & Medicaid Services (CMS), *Medicaid and CHIP 2014 Improper Payments Report*, (Baltimore, MD). CMS examined fee-for-service improper payments by type of Medicaid service and reported, for the top 10 service types, the projected dollars in error. The report also includes the projected dollars in error and improper payment rate for all other Medicaid services combined, which, for comparison, was about \$1.9 billion and 2.8 percent, respectively.

Two CMS Systems Collect Data on the Provision of and Spending on Personal Care Services, and the Data Suggest Wide Variations among States

Two CMS data systems collect Medicaid data from providers' records of services rendered and total Medicaid expenditures by broad Medicaid categories of service, including for personal care services. Based on our assessment of the data collected from the two data systems, these data can be reliably used to provide a summary description of the provision of and spending on personal care services, including aggregate annual spending and proportion of Medicaid beneficiaries that received these services. These data suggest wide variation among states in the provision of and spending on personal care services.

Two CMS Systems Collect Data on the Provision of and Spending on Medicaid Personal Care Services

Two CMS data systems collect data related to the provision of and spending on Medicaid personal care services at the state and national level. Both data systems contain data collected by states and submitted to CMS. Each system has a different purpose and the type and scope of the data each collects reflects its purpose. The Medicaid Statistical Information System (MSIS) was established to collect detailed information on the services rendered to individual Medicaid beneficiaries. The Medicaid Budget and Expenditure System (MBES) was established for states to report total aggregate expenditures for Medicaid services across broad service categories.

Medicaid Statistical Information System

MSIS is a national data system maintained by CMS that collects data from state records on fee-for-service claims for services rendered to Medicaid beneficiaries and managed care encounter records for services delivered through managed care. Each state transmits digital files to CMS quarterly using MSIS. MSIS was designed to provide CMS with a detailed, national database of Medicaid program information to support a broad range of program management functions, including health care research and evaluation, program utilization and spending forecasting, and analyses of policy alternatives.

MSIS collects information on the beneficiary receiving services and on the services provided. Beneficiary information includes a beneficiary's age and basis for Medicaid eligibility. Information on the services provided includes:

- the date the service was provided;

-
- the place where the service was provided;
 - the general type of service provided;
 - a procedure code that identifies the specific service provided; and
 - a provider identification number that identifies the Medicaid provider who rendered services.

Payment information is collected for fee-for-service claims, which are paid by the state, but not for managed care encounters, which are paid for by managed care organizations that contract with the state. Federal law requires that all data submitted be consistent with the standardized MSIS format and data elements as a condition of receiving federal reimbursement for mechanized claims processing systems.²²

CMS reviews these MSIS files for initial quality and proper formatting and returns any files that do not pass its quality tests back to states for correction and resubmission. State MSIS submissions are compiled into calendar year data sets that provide beneficiary-level data on eligibility, service utilization, and payments for every state Medicaid program. CMS can make the data files available for analysis to researchers and others that submit a data use agreement approved by CMS.²³

Medicaid Budget and Expenditure System

MBES is a national expenditure reporting system that collects each states' total aggregate Medicaid expenditures reported to CMS by broad categories of service for the purpose of states' obtaining the federal share of their payments to providers and for other approved expenditures.

²²MSIS replaced the hard copy form CMS-2082, titled *The Statistical Report on Medical Care: Eligibles, Recipients, and Services*. Prior to MSIS, states were required to complete and submit the CMS-2082 in hard copy.

²³CMS developed a research-friendly data set for this purpose, called the Medicaid Analytic eXtract (MAX), which is a set of beneficiary-level data files derived from state-submitted MSIS claims data on Medicaid eligibility, service utilization, and payments. We used MAX data to analyze claims for personal care services because they are more reliable and consistent than states' quarterly MSIS reports. Due to the significant lag time in MAX data availability for some states, our analysis for 2012 does not include every state—35 were available at the time of our analysis. For purpose of this report we refer MAX data as MSIS data because MAX is based on state MSIS data submissions.

States are required to use this web-based system to input and transmit electronically a form referred to as the CMS-64 on a quarterly basis.²⁴

MBES contains state Medicaid expenditures in over 80 broad categories of services and total expenditures for each state. These data come from CMS-64 reports, which CMS requires states to use to report their Medicaid expenditures through specified, standard categories of service such as inpatient hospital services, nursing facility services, physician services, and HCBS services by type of program.²⁵ For each category of service, the CMS-64 collects a state's total Medicaid expenditure, the federal share, and the nonfederal share. The CMS-64 does not collect beneficiary-specific payment information or expenditures for specific types of services. For example, all expenditures for regular inpatient hospital services are reported on one category-of-service line. Data from the CMS-64 do, however, represent the most reliable and comprehensive information on aggregate Medicaid spending, including spending on program administration.

In addition to its primary purpose of capturing states' expenditures for purposes of states obtaining federal matching payments for their expenditures, MBES data are used to produce national and state-specific Medicaid expenditure reports by the standard categories of services. CMS compiles the reports by federal fiscal year and makes these yearly expenditure files available to the public on its website.

²⁴The Form CMS-64 is titled *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program*. For purposes of this report, we refer to this form as the "CMS-64."

²⁵States are required to retain detailed documentation that they use to compile and report expenditures by the CMS-64 category of services, but these data are not reported to CMS through MBES.

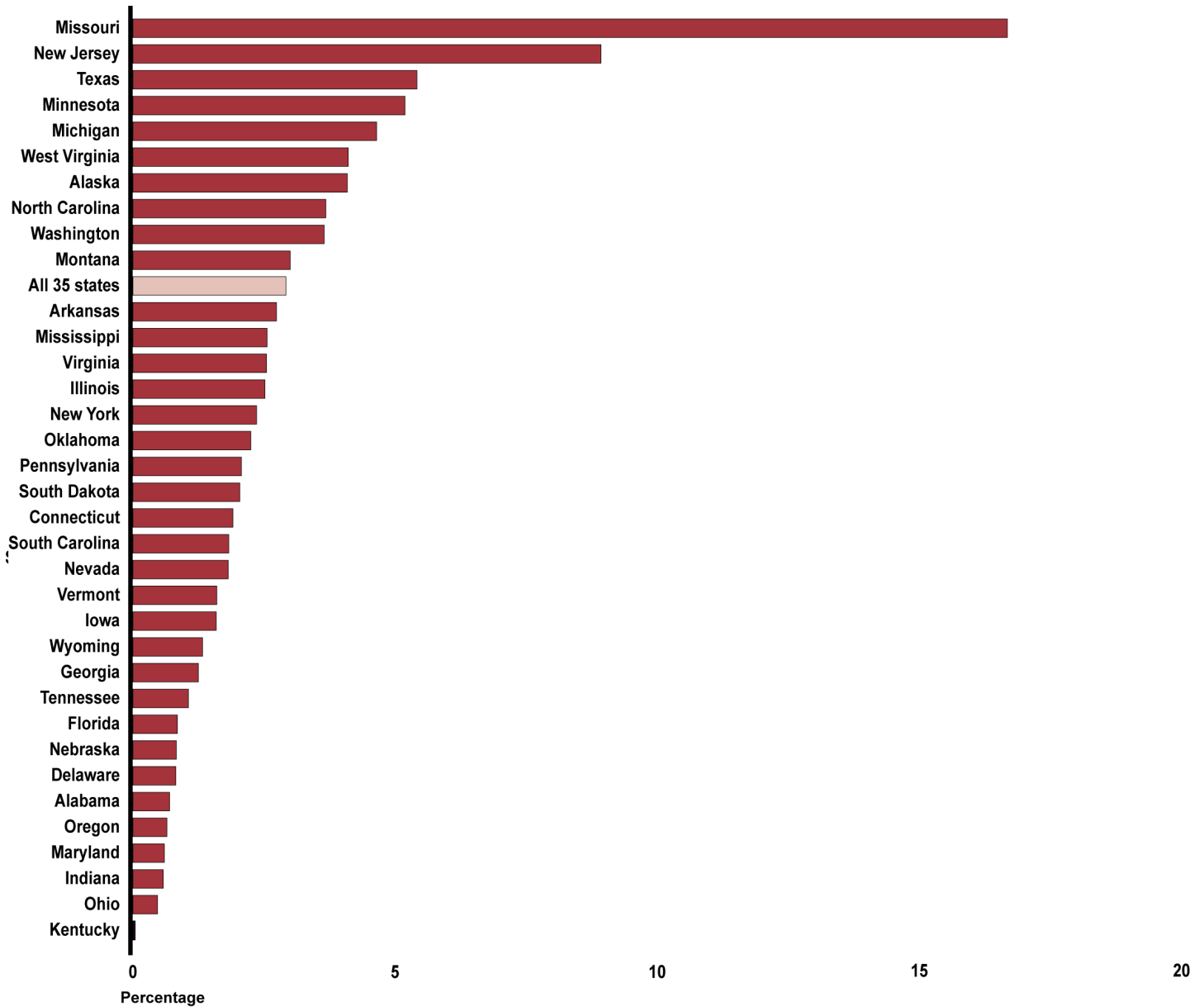
Data Available from the Two CMS Systems Suggest Wide Variations across Reviewed States in the Provision of and Spending on Personal Care Services

Available information from MSIS and MBES suggest that the provision of and spending on personal care services varies widely across states. Specifically, the most recent and complete MSIS claims data available to us for 35 states from calendar year 2012 suggest variation across these states in the provision of personal care services, including differences in: the types of beneficiaries served, the delivery model under which they are served (fee-for-service or managed care), and the average payment per beneficiary. Similarly, MBES expenditure data for all states for calendar years 2012 through 2015 show variation across states in total spending on personal care services and spending by type of program.

Data from the Medicaid Statistical Information System

Analysis of calendar year 2012 MSIS data for 35 states indicates that, overall, nearly 3 percent of all Medicaid beneficiaries in these states—about 1.5 million individuals—received personal care services at least once. However, the percentage of beneficiaries receiving services varied among the states. As illustrated in figure 2, the percentage of each state’s Medicaid beneficiaries who used personal care services at least once ranged from less than 1 percent of beneficiaries in 9 states to almost 17 percent in 1 state.

Figure 2: Percent of 35 States' Medicaid Beneficiaries Who Have Received Personal Care Services at Least Once in Calendar Year 2012



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Note: Data include both fee-for-service claims and managed care encounters.

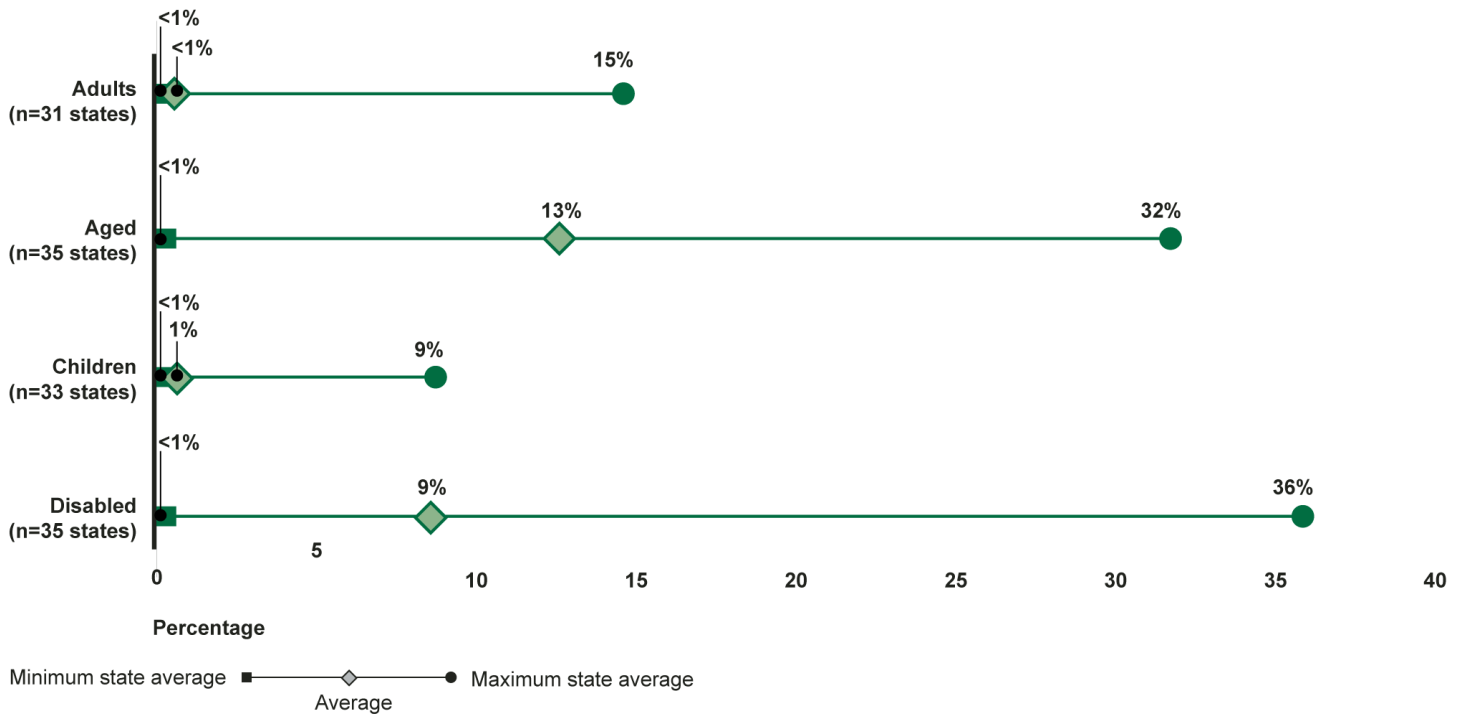
MSIS data also show wide variation in the percentage of beneficiaries who received personal care services across the four main eligibility

groups we analyzed (children, adults, aged individuals, and disabled individuals).²⁶ For example, as illustrated in figure 3, all 35 of the states with available data provided personal care services to aged and disabled beneficiaries, but some more so than others. Across the 35 states, about 13 percent of aged and about 9 percent of disabled beneficiaries received personal care services in 2012. The proportions receiving personal care services in individual states ranged from less than 1 percent to about 32 percent of aged and from less than 1 percent to 36 percent of disabled beneficiaries. The average percentage of adults and children who received personal care services across all the 35 states was much smaller than the aged and disabled groups (less than 1 percent), and the data suggest that a few states did not provide any personal care services to individuals in the adult and children groups.²⁷

²⁶For purposes of our analysis, we report claims and encounter data on the basis of the four main eligibility groups. Individuals who are eligible for Supplemental Security Income based on disability status are classified as disabled; other Medicaid beneficiaries are classified based on their age at the time the data were reported—child (0-18), adult (19-64), or aged (65 and older).

²⁷A few states' data did not include personal care services claims or encounters for adult or children, however, these states had claims or encounters for disabled beneficiaries, including those that were adults and children. Beneficiaries are identified as disabled regardless of their age when they are enrolled in Medicaid based on their eligibility for Supplemental Security Income.

Figure 3: Percentage of Medicaid Beneficiaries Who Received Personal Care Services in Calendar Year 2012 in 35 States, with Minimums and Maximums, by Eligibility Group



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

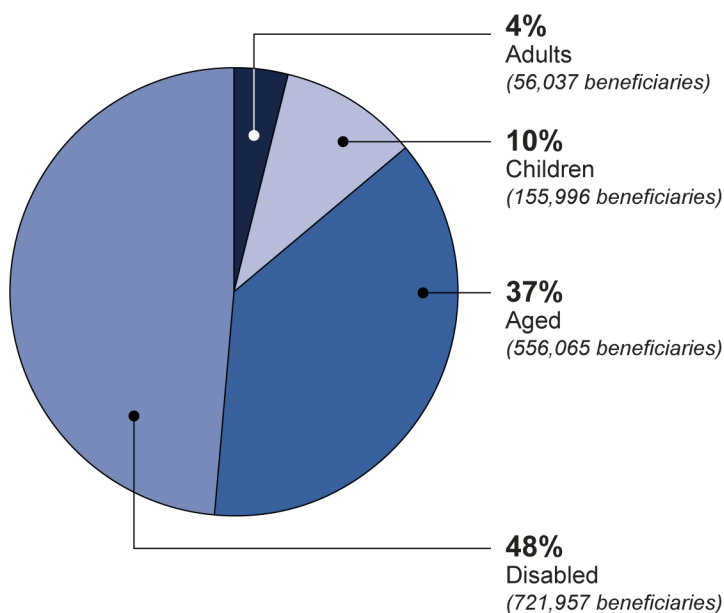
Notes: Data include beneficiaries' basis for enrollment, which we condense to four mutually exclusive groups: Children (0 through 18), adults (19 through 65), the aged (older than 65), and disabled, which may include beneficiaries of any age eligible for Medicaid because they received Supplemental Security Income. Data include both fee-for-service claims and managed care encounters. Averages are calculated based on the total number of recipients in each eligibility group divided by the number beneficiaries in states serving each group. For adults and children, we only included states that provided personal care services to these groups.

When examining just those beneficiaries who received personal care services in 2012, MSIS data show that most were in the disabled or aged eligibility categories, but that the composition of each state's recipients varied widely. Of the nearly 1.5 million beneficiaries who received personal care services that year in the 35 states, the vast majority—nearly 86 percent—were either aged or disabled. Disabled beneficiaries represented 48 percent and aged beneficiaries represent 37 percent of all those receiving personal care services. Children and adults represented a

much smaller share of the beneficiaries that received personal care services in 2012 in these states, at 10 percent and 4 percent, respectively (see figure 4). However, children and adults made up more than 90 percent of the disabled group in the 35 states.²⁸

Figure 4: Composition of Beneficiaries in 35 States Who Received Personal Care Services at Least Once in Calendar Year 2012, by Eligibility Group

Total number of beneficiaries: 1,490,055



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Notes: Data include beneficiaries' basis for enrollment, which we condense to four mutually exclusive groups: Children (0 through 18), adults (19 through 64), the aged (65 or older), and disabled, which may include beneficiaries of any age eligible for Medicaid because they received Supplemental Security Income. Data include both fee-for-service claims and managed care encounters.

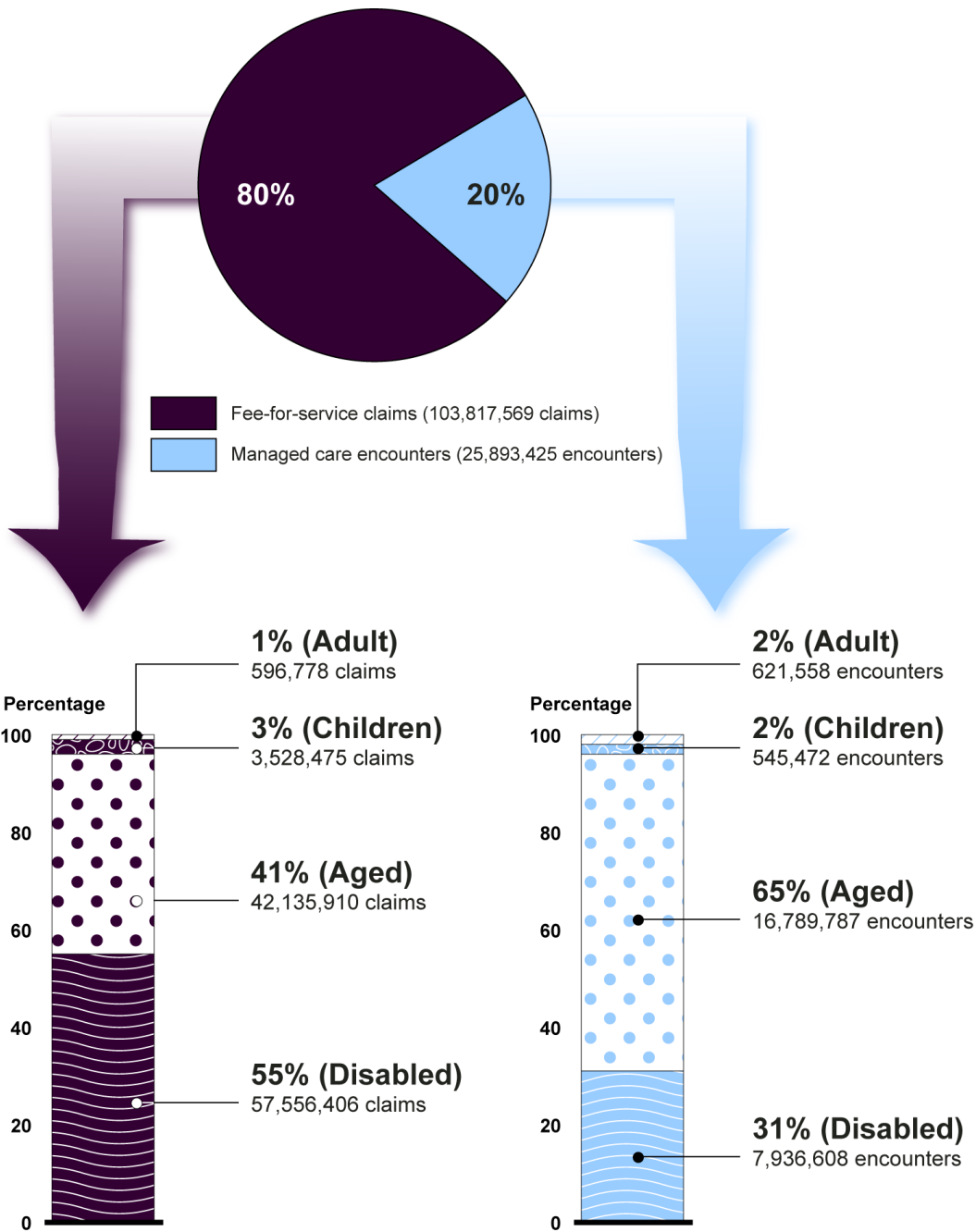
The 2012 MSIS data for the 35 states show that most personal care services are provided under a fee-for service delivery model, rather than under a managed care delivery model. About 80 percent of personal care services in the 35 states were provided under a fee-for-service model,

²⁸The disabled eligibility group includes individual of all ages, with children (age 0 through 18), adults (age 19 through 64), and aged individuals (age 65 and older) representing 14, 79, and 7 percent, respectively.

with 20 percent delivered through a managed care model. Most of the claims under fee-for-service models were for services provided to disabled beneficiaries, while most of the services under managed care models were provided to aged beneficiaries (see figure 4).²⁹ The majority of the 35 states (20) provided 100 percent of their personal care services under a fee-for-service model, and nearly all of the remaining states provided the majority of their services (i.e., greater than 50 percent) this way; only 3 states provided a majority of personal care services through a managed care model. No states relied exclusively on a managed care model for all beneficiaries, although one state—Tennessee—used a managed care model exclusively for the adult eligibility group.

²⁹Our August 2016 report on access to Medicaid services likewise showed that disabled beneficiaries were among the most likely to receive Medicaid services under a fee-for-service delivery model. See *Medicaid Fee-For-Service: State Resources Vary for Helping Beneficiaries Find Providers*. [GAO-16-809](#) (Washington, D.C., Aug. 29, 2016).

Figure 5: Percent of Personal Care Services Claims and Encounters in 35 States, and the Composition of Medicaid Beneficiaries Who Received Services, by Eligibility Group, in Calendar Year 2012



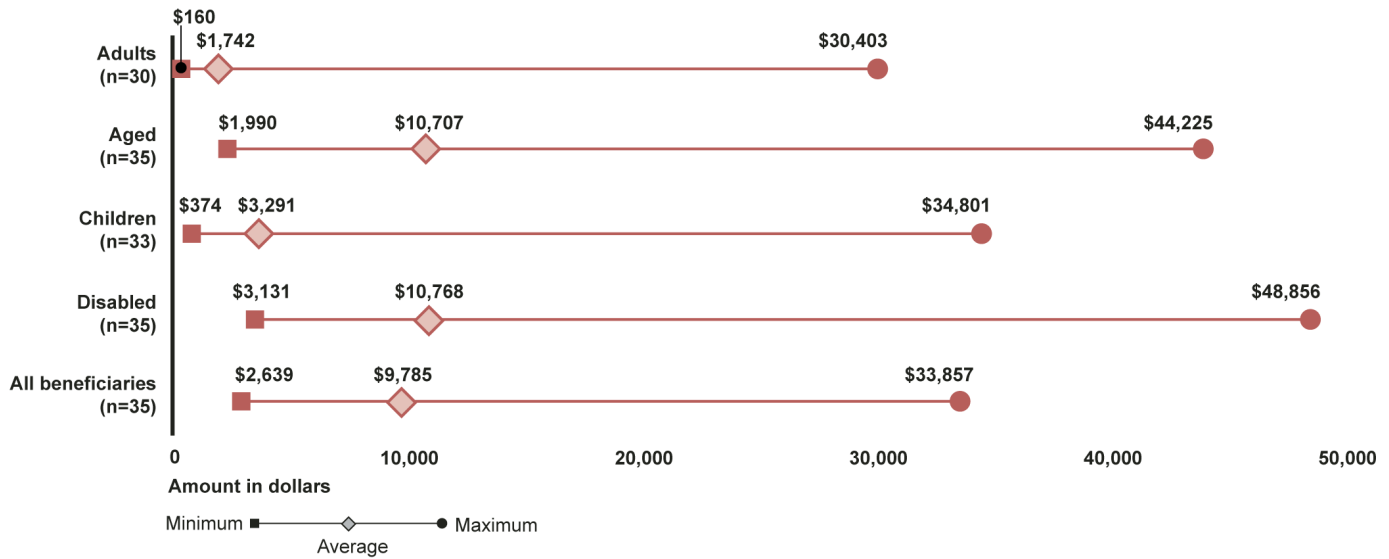
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Notes: All 35 states provided personal care services under a fee-for-service delivery model, 18 of which also provided service through managed care. Data include beneficiaries' basis for enrollment, which we condense to four mutually exclusive groups: Children (0 through 18), adults (19 through 65), the aged (older than 65), and disabled, which may include beneficiaries of any age eligible for Medicaid because they received Supplemental Security Income.

MSIS fee-for-service claims data for 2012 show variation in the average total payments made per beneficiary and by type of beneficiary for personal care services across the 35 states.³⁰ For beneficiaries who received personal care services under a fee-for-service model that year, the average total payment per beneficiary was \$9,785. As illustrated in figure 6, average total payments per beneficiary varied across eligibility groups. For example, average total payments for personal care services per beneficiary ranged from \$1,742 for adults to more than \$10,786 for disabled beneficiaries. In addition, average total payments varied significantly across states. Across all eligibility groups, average total payments for personal care services ranged from \$2,639 in Wyoming to \$33,857 in Delaware, a nearly 13-fold difference. For disabled beneficiaries, the range in average total payment was even greater—from \$3,131 to \$48,856—a nearly 16-fold difference, also represented by Wyoming and Delaware.

³⁰We do not provide a similar analysis of personal care services delivered under managed care because MSIS does not collect managed care payment amounts.

Figure 6: Average Annual Medicaid Payments Per Beneficiary in 35 States for Personal Care Services Provided under Fee-for-Service Delivery Models for 2012, by Eligibility Group



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Notes: Data include beneficiaries' basis for enrollment, which we condense to four mutually exclusive groups: Children (0 through 18), adults (19 through 65), the aged (older than 65), and disabled, which may include beneficiaries of any age eligible for Medicaid because they received Supplemental Security Income. Analysis is based on fee-for-service payment amount only, as payment amounts are not collected for managed care encounters. Averages for each eligibility group are calculated based on total payments divided by the number recipients in states serving each eligibility group. For Adults and Children, we only included states that provided personal care services to these groups.

Data from the Medicaid Budget and Expenditure System

Expenditure data contained in the MBES, as reported by all 50 states and the District of Columbia, revealed total personal care spending on a fee-for-service basis of about \$15 billion in calendar year 2015.³¹ As illustrated in figure 6, however, more than three-quarters of the reported spending was for personal care services provided under two types of programs: State Plan Personal Care Services and Community First Choice. Specifically, based on state-reported data, spending under State

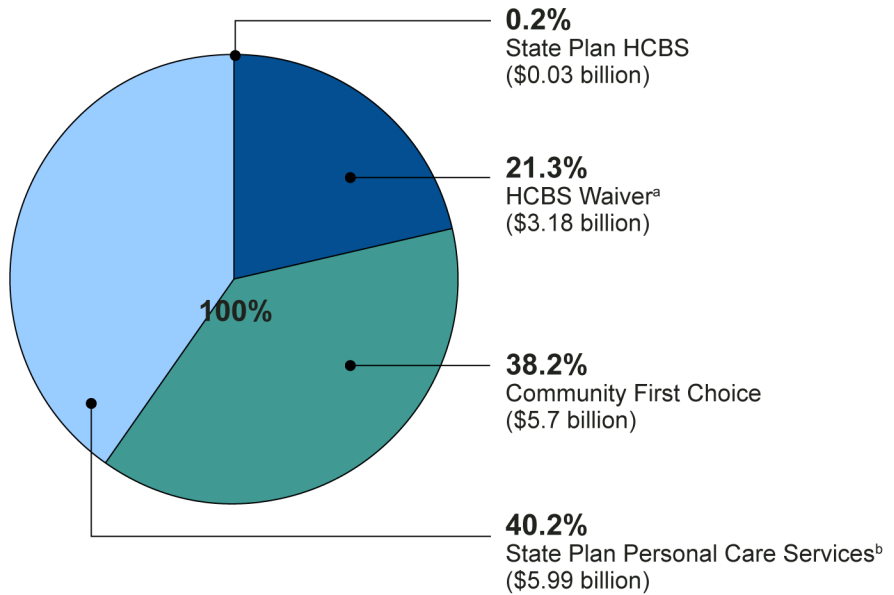
³¹CMS-64 expenditure data from the MBES was extracted on March 14, 2016; however, states have up to 2 years to submit additional or revised expenditure data. Additionally, because personal care spending services under managed care is reported in the aggregate with other home- and community-based services, the personal care services expenditures presented in this report are limited to services provided under fee-for-service delivery models.

Plan Personal Care Services was slightly higher in 2015 at nearly \$6 billion than the \$5.7 billion in spending for Community First Choice. These two programs have fewer and less stringent federal oversight requirements than the HCBS Waiver and State Plan HCBS programs. In contrast, spending on personal care services under these two programs was less overall, with spending on personal care services under HCBS Waiver programs totaling \$3.2 billion and \$34 million under State Plan HCBS programs.³² For HCBS Waiver and State Plan Personal Care Services programs, states reported less than 1 percent of their expenditures for personal care services under the Participant-Directed Option.³³

³²For expenditures under the HCBS Waiver, State Plan HCBS, and Community First Choice programs, the CMS-64 includes a single expenditure line for each program type that collects all HCBS expenditures. However, states are also required to report expenditures for different services provided under these programs, including personal care services, on separate lines, which allowed us to identify and analyze personal care spending under these program types.

³³Section 1915(j) of the Social Security Act allows states to implement the Participant-Directed Option in conjunction with either State Plan Personal Care Services or HCBS Waiver programs.

Figure 7: State Reported Fee-for-Service Spending on Personal Care Services in 2015 for All States, by Program Type



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Note: Data are for all 50 states and the District of Columbia.

^aBased on expenditure data submitted by states for 2015, none of the HCBS Waiver expenditures were for services delivered under the Participant-Directed Option.

^bBased on expenditure data submitted by states for 2015, about 0.36 percent of all State Plan Personal Care Services expenditures were for services delivered under the Participant-Directed Option.

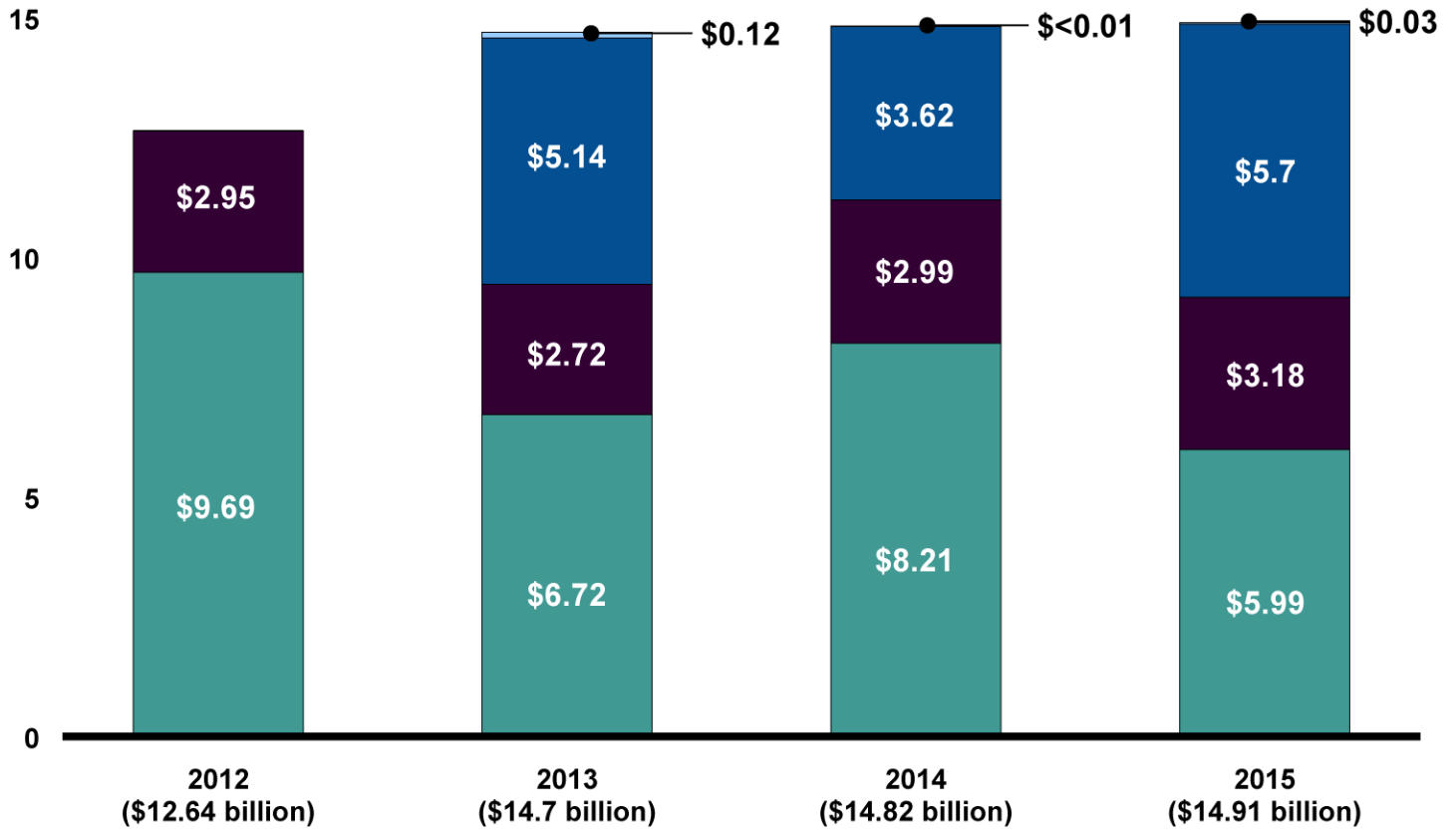
The state-reported expenditure data contained in the MBES reveal how total spending on personal care services has changed over time, both in total amounts and in the amounts associated with each program type. As illustrated in figure 8, state-reported expenditure data suggest that after a spending increase of over \$2 billion in from calendar year 2012 to 2013, total fee-for-service spending on personal care services increased more

slowly, by about \$100 million a year from 2013 through 2015.³⁴ Moreover, the data show a significant share of spending on personal care services under the Community First Choice program beginning in 2013.

³⁴The fee-for-service data from MBES likely understates growth in total expenditures for personal care services because it does not include services provided under managed care delivery models. States have increasingly used managed long-term care services and supports to provide HCBS, including personal care services. According to a recent report contracted by CMS, spending on Managed long-term services and supports increased by 55 percent in FY 2014. See Truven Health Analytics, *Medicaid Expenditures for Managed Long-Term Services and Supports in FY 2014* (Bethesda, MD: 2016).

Figure 8: State Reported Fee-for-Service Spending on Personal Care Services for Calendar Years 2012 through 2015 for All States, by Program Type

Dollars in billion



Year and total PCS expenditures

- State Plan Personal Care Services
- HCBS Waiver
- State Plan HCBS
- Community First Choice

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Note: Data are for all 50 states and the District of Columbia.

Limitations in Data Hinder CMS Oversight of Personal Care Services, and Planned Improvements May not Address Data Limitations

CMS's two data systems provide some basic and aggregate information on the provision of and spending on personal care services. However, in order to provide effective oversight, CMS needs detailed data on personal care services that are timely, complete, consistent, and accurate, including data on who provided the service, the type and amount of services provided, when services were provided, and the amount the state paid for services. We found that the detailed data collected by the two systems were not always timely, complete, consistent, or accurate, which limits the usefulness of these data for CMS oversight.

CMS Does Not Collect Sufficiently Complete or Consistent Data from States on Medicaid Personal Care Services Needed to Monitor the Provision of and Spending on These Services

CMS does not collect data that are timely, or are sufficiently complete, consistent, and accurate to effectively monitor the provision of and spending on Medicaid personal care services.

Medicaid Statistical Information System Data Collected by CMS Are Not Timely and are Often Incomplete or Inconsistent

Medicaid personal care services claims and encounter data collected by CMS through MSIS are not timely, and available data are often incomplete and inconsistent, based on our analysis of 2012 data from 35 states. States are required by federal law to develop and operate their own claims-processing and information-retrieval systems and submit data to CMS, through MSIS, that includes information on the specific services provided, the beneficiaries receiving these services, and the providers delivering these services.³⁵ Federal law requires states to submit data

³⁵Since 1999, states have been required to submit encounter data to CMS for beneficiaries receiving services through managed care delivery systems. The Balanced Budget Act of 1997 required states to submit detailed individual enrollee encounter data to CMS as a condition of receiving federal reimbursement for mechanized claims processing systems. Pub. L. No. 105-33, § 4753, 111 Stat. 251, 525 (1997) (codified at 42 U.S.C. § 1396b(r)(1)(F)).

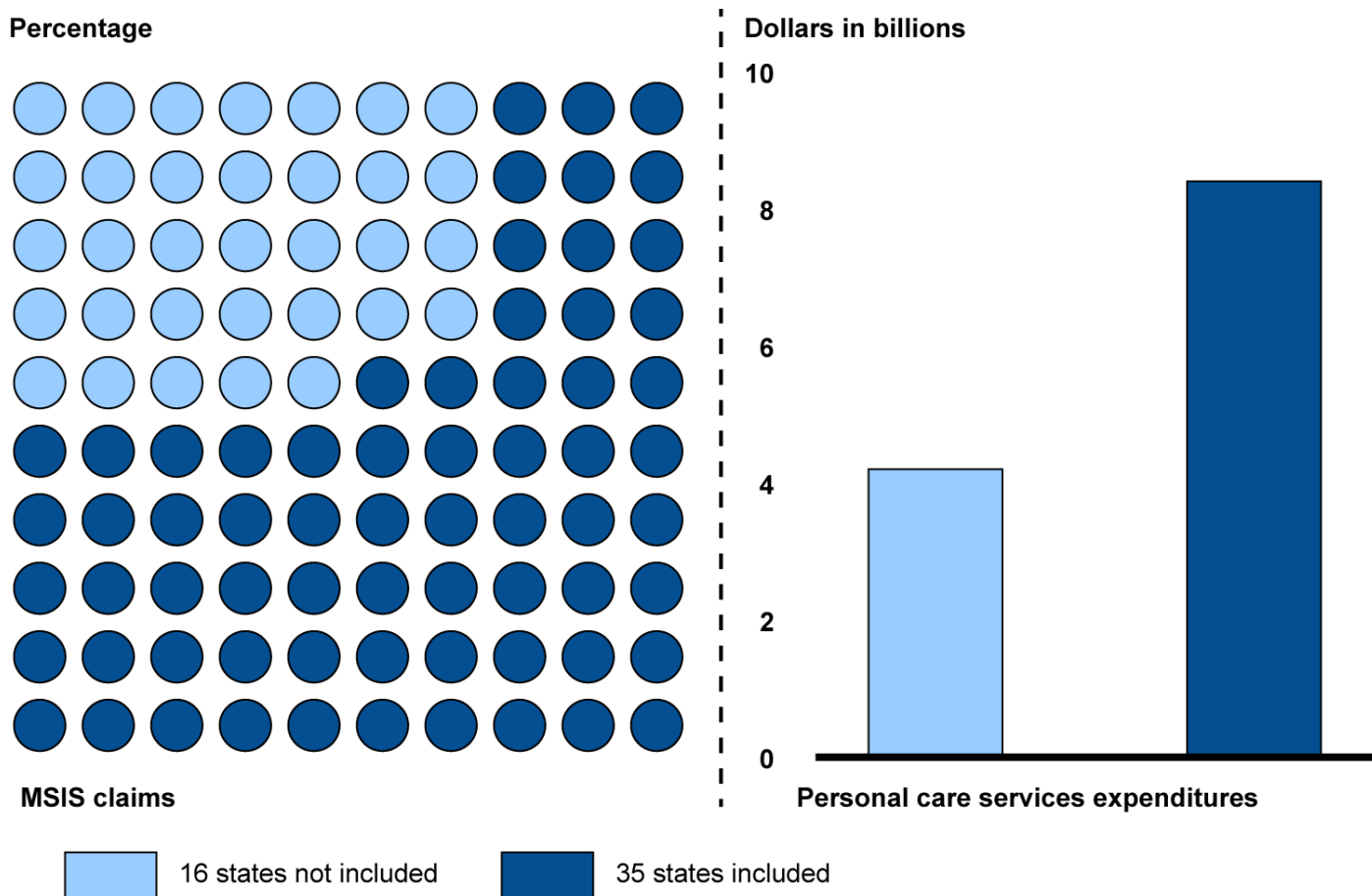
that are consistent with the standardized MSIS format and data elements as a condition of receiving federal reimbursement for mechanized claims processing systems. CMS has established specific reporting guidance for some of these data elements but not for others. MSIS was designed to provide CMS with a detailed, national database of Medicaid program data to support a broad range of program management functions, including health care research and evaluation by CMS and other researchers, program utilization and spending forecasting, and analyses of policy alternatives.

The information CMS collects through MSIS from states is not timely. Data are typically not available for analysis and reporting by CMS or others for several years after services are provided. This happens for two reasons. First, although states have 6 weeks following the completion of a quarter to report their claims data, their reporting can be delayed as a result of providers and managed care plans not submitting data in a timely manner, according to the CMS contractor responsible for compiling data files of Medicaid claims and encounters. For example, providers may submit claims for fee-for-service payments to the state late and providers may need to resubmit claims to make adjustments or corrections before they can be paid by the state. Second, the contractor analyzes the MSIS data submitted by the states and compiles annual person-level claims files that are in an accessible format. The contractor also conducts quality-control checks and corrects data errors and consolidates multiple records that may exist for one claim. This process, for one year of data, can take several years and, as a result, when information from claims and encounters becomes available for use by CMS for purposes of program management and oversight, it can be several years old.

Information CMS collects from states through MSIS is also incomplete in two ways. First, specific data on beneficiaries' personal care services were not included in the calendar year 2012 MSIS data for 16 states. Nevertheless, these 16 states received federal matching funds for the \$4.2 billion in total fee-for-service payments for personal care services

that year—about 33 percent of total expenditures for personal care services reported by all states (see figure 9).³⁶

Figure 9: Percentage of Calendar Year 2012 Personal Care Services Fee-For-Service Expenditures for States That Were and Were Not Included in the Medicaid Statistical Information System Data



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Note: For purposes of this analysis we include the District of Columbia and refer to it as a state. The 35 states included in the Medicaid Analytic eXtract for 2012 were Alaska, Alabama, Arkansas,

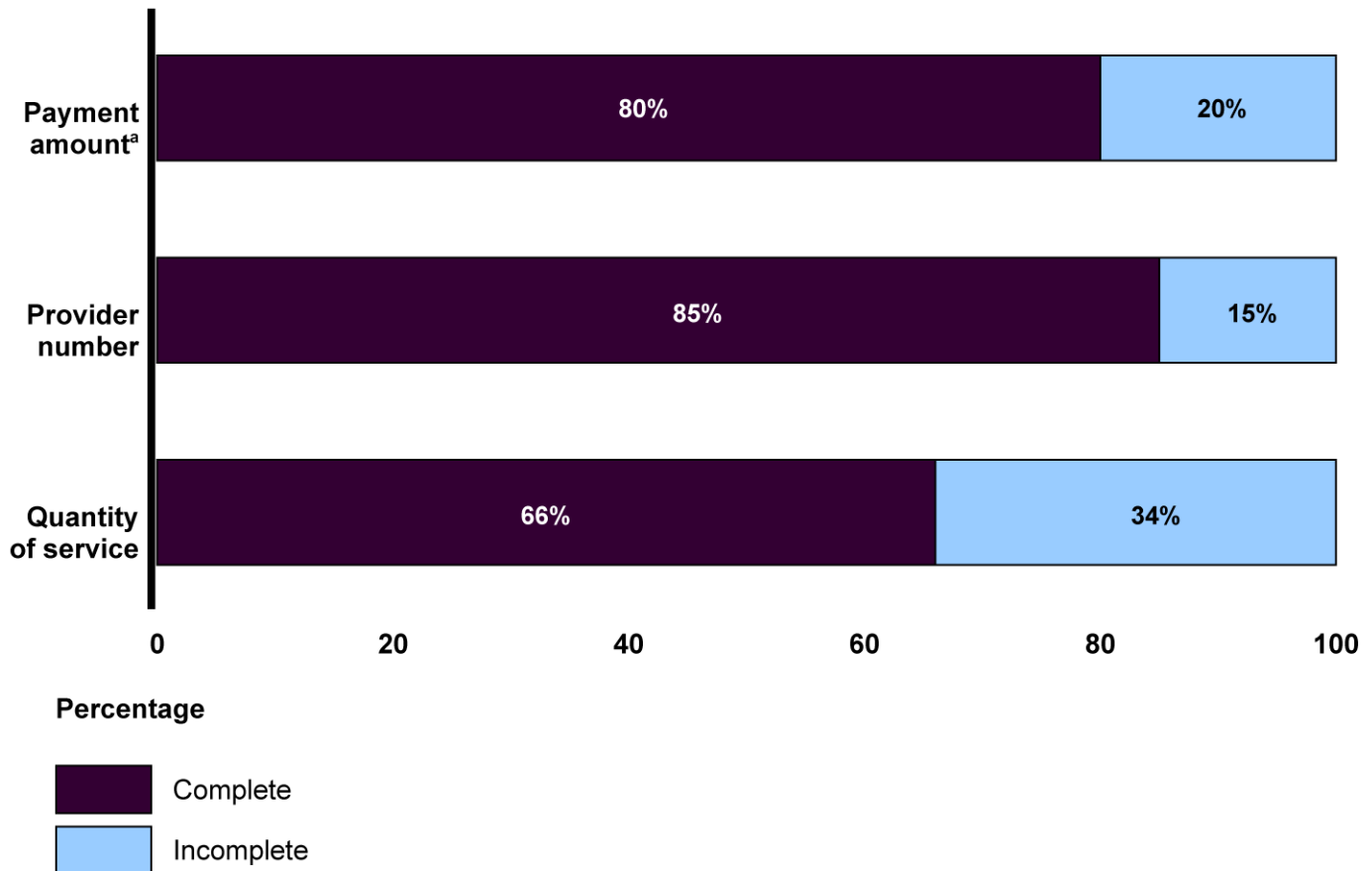
³⁶To estimate the Medicaid personal care services expenditures associated with the 16 missing states, we analyzed aggregate fee-for-service expenditures for these services as reported by these states through the Medicaid Budget and Expenditure System.

Connecticut, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, North Carolina, Nebraska, New Jersey, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Vermont, Washington, West Virginia, and Wyoming. The 16 states not included were Arizona, California, Colorado, District of Columbia, Hawaii, Idaho, Kansas, Louisiana, Maine, Massachusetts, New Hampshire, New Mexico, North Dakota, Rhode Island, Utah, and Wisconsin.

Second, even for the 35 states for which 2012 MSIS claims and encounter data were available, certain data elements collected by CMS were incomplete. For example, for the records we analyzed, 20 percent included no payment information, 15 percent included no provider identification number to identify the provider of service, and 34 percent did not identify the quantity of services provided (see figure 10).³⁷

³⁷We previously reported that managed care encounter data submitted by states to CMS have been relatively incomplete and unreliable. See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*. [GAO-15-481](#) (Washington, D.C.: May 29, 2016).

Figure 10: Percentage of 2012 Medicaid Claims and Encounters for Personal Care Services in 35 States That Had Complete Information on Payment, Provider Information, and the Quantity of Services Provided



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

^aPayment amounts are available for claims made under a fee-for-service delivery model; payments made to providers under managed care are not included in the data.

Incomplete data limit CMS’s ability to track spending changes and corroborate spending with reported expenditures because they lack important information on a significant amount of Medicaid payments for personal care services. For example, among the 2012 claims for personal care services under a fee-for-service delivery model, claims without a provider identification number accounted for about \$4.9 billion in total payments. Similarly, payments for fee-for-service claims with missing information on the quantity of personal care services provided totaled about \$5.1 billion.

Even when key information was included in claims and encounter data, it was often inconsistent, which limits the effectiveness of the data to identify questionable claims and encounters. For purposes of oversight, a complete record (claims or encounters) should include data for each visit with a provider or caregiver, with specified dates of service, and it should use a clearly specified unit of service (e.g., 15 minutes) along with a standard definition of the type of service provided. These data allow CMS and states to analyze claims to identify potential fraud and abuse. The following examples illustrate inconsistencies in the data from the 35 states:

- States used hundreds of different procedure codes for personal care services. Procedure codes on submitted claims and encounters were inconsistent in three ways: the number of codes used by states; the use of both national and state-specific codes; and the varying definitions of different codes across states. More than 400 unique procedure codes were used by the 35 states. CMS does not require that states use standard procedure codes for personal care services; instead, states have the discretion to use state-based procedure codes of their own choosing or national procedure codes. As a result, the procedure codes used for similar services can differ from state to state, limiting CMS's ability to use this data as a tool to compare and track changes in the use of specific personal care services provided to beneficiaries because CMS cannot easily compare similar procedures by comparing service procedure codes.
- States used widely varying units of service associated with numerous procedure codes. As a result of the numerous procedure codes used by states, the units of service for personal care services varied widely. Depending on the code used, units of service can be in 15-, 30-, or 60-minute increments, or as per diem codes. The absence of information about the unit of service in the millions of records for personal care services, combined with states' use of hundreds of different codes, makes it difficult to efficiently assess the extent that services provided are reasonable. Claims and encounter records generally include the procedure code, but do not identify the unit of service associated with the code. Claims for multiple units of service may be reasonable if the unit represents a 15-minute increment. However, if the unit of service represents an hour the number of units billed may not be reasonable. For example, for a beneficiary requiring 2 hours of personal care services, a claim containing 8 units in a single day is reasonable if the unit of service is 15 minutes but would not be reasonable if the unit of service is an hour. Without consistent procedure codes with defined units of service, the utilization and

expenditure analyses done by CMS and others with the data are difficult to complete, including assessing the reasonableness of the amount of services claimed and identifying potentially inappropriate claims. In general, we found that claims for 2012 represented large quantities of services. Among claims with valid quantity of service data—that is, where the claim identified a procedure code and the number of units provided—quantities reported ranged from 1 unit to more than 27,000 units, with an average quantity of 15 units. For the most commonly used procedure, which represents 15 minutes of service by a personal care attendant, the average quantity would translate into nearly 4 hours of personal care services billed as a single claim. For seven states, 100 percent of cases were missing information on the quantity of services delivered.

- State-reported dates of service were overly broad. In the 35 states whose claims we could review, some claims for personal care services had dates of services (i.e., start and end dates) that spanned multiple days, weeks, and in some cases months. For 12 of the 35 states, 95 percent of their claims were billed for a single day of service. However, in other states, a number of claims were billed over longer time periods. For example, for 10 of the states, 5 percent of claims covered a period of at least 1 month, and 9 states submitted claims that covered 100 or more days. When states report dates of service that are imprecise, it is difficult to determine the specific date for which services were provided and identify whether services were claimed during a period when the beneficiary is not eligible to receive personal care services—for example, when hospitalized for acute care services.

Others have also found the poor quality of personal care services data submitted to CMS to be a long-standing problem. Based on numerous reviews of states' personal care services programs, the HHS OIG determined that the limited or missing information on personal care service providers, dates of service, and quantity of services were an impediment to effective program integrity and oversight.³⁸ The HHS OIG

³⁸The HHS OIG conducted 23 audit and evaluation reports on personal care services claims data between 2006 and 2012 and consistently found payment, compliance, and oversight vulnerabilities. See U.S. Department of Health and Human Services, Office of the Inspector General, *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement—A Portfolio*. OIG-12-12-01, Washington, D.C. (November 2012).

found that the data could not be used to accurately identify overlapping claims because it was common for providers to submit one claim for multiple instances of personal care services provided over days, weeks, or months. The HHS OIG also found that with overlapping dates it is difficult to identify instances when beneficiaries were receiving institutional services and therefore were ineligible for home-based personal care services. Further, the HHS OIG found that claims for personal care services did not include unique identifiers for personal care attendants and that cases of fraud often involved impossible or improbable volumes of service or service patterns, for example, claims for more than 24 hours in a day or claims for services in multiple beneficiary homes during the same day. The HHS OIG concluded that, if the availability and quality of personal care data were improved, investigators could analyze the data to identify and follow up on aberrancies and questionable billing patterns. Based on its findings, the OIG recommended that CMS takes steps to reduce variation in how states are documenting claims for personal care services, among other recommendations.³⁹

Medicaid Budget and Expenditure System Data Collected by CMS Are Not Always Accurate or Complete

Medicaid personal care services expenditure data collected from states by CMS and contained in the MBES are not always accurate or complete, according to our analysis of states' reported expenditures for calendar years 2012 through 2015. CMS requires states to report expenditures for personal care services on specific lines on the CMS-64. The required reporting lines correspond with the specific types of programs under which states have received authority to cover personal care services, and can affect the federal matching payment amounts states receive when seeking federal reimbursement. For example, a 6 percent increase in federal matching is available for services provided through the

³⁹The HHS OIG identified this recommendation on its list of 25 most crucial unimplemented recommendations. Specifically, the HHS OIG recommended that CMS issue regulations for states to (1) enroll all personal care attendants as providers or require all attendants to register with their State Medicaid agencies and assign each attendant a unique identifier and (2) require that claims for personal care services include the specific date(s) when services were performed and the identity of the personal care attendant. See U.S. Department of Health and Human Services, Office of the Inspector General, *Compendium of Unimplemented Recommendations*, Washington, D.C. (April 2016).

Community First Choice program.⁴⁰ For personal care services provided under the State Plan PSC program, CMS requires states to report their expenditures on one of two lines of the CMS-64.⁴¹ For personal care services provided under the three other programs—HCBS Waiver, State Plan HCBS, and Community First Choice—CMS requires states to report their expenditures for personal care services separately from other types of services provided under each program. CMS requires these states to submit expenditure amounts for specific service types on what CMS refers to as feeder forms—that is, expenditure lines on the CMS-64 that feed into the total HCBS spending amount under a state’s HCBS Waiver program. The MBES system automatically generates the state’s total HCBS Waiver program spending by combining the expenditures reported for each of the various specific services.⁴²

We found that not all states are reporting their personal care services expenditures accurately, and as result, personal care services expenditures may be underreported or reported in an incorrect category. We compared personal care services expenditures from all states’ CMS-64 reports for calendar years 2012 through 2015 with each state’s approved programs during this time period and found that about 17 percent of personal care services expenditure lines were not reported correctly. As illustrated in figure 11, nearly two-thirds of the reporting errors were a result of states not separately identifying and reporting personal care services expenditures using the correct reporting lines, as required by CMS. Without separate reporting of personal care expenditures as required, CMS is unable to monitor how spending changes over time across the different program types and have an accurate estimate of the magnitude of potential improper payments for personal care services. The other types of errors involved states

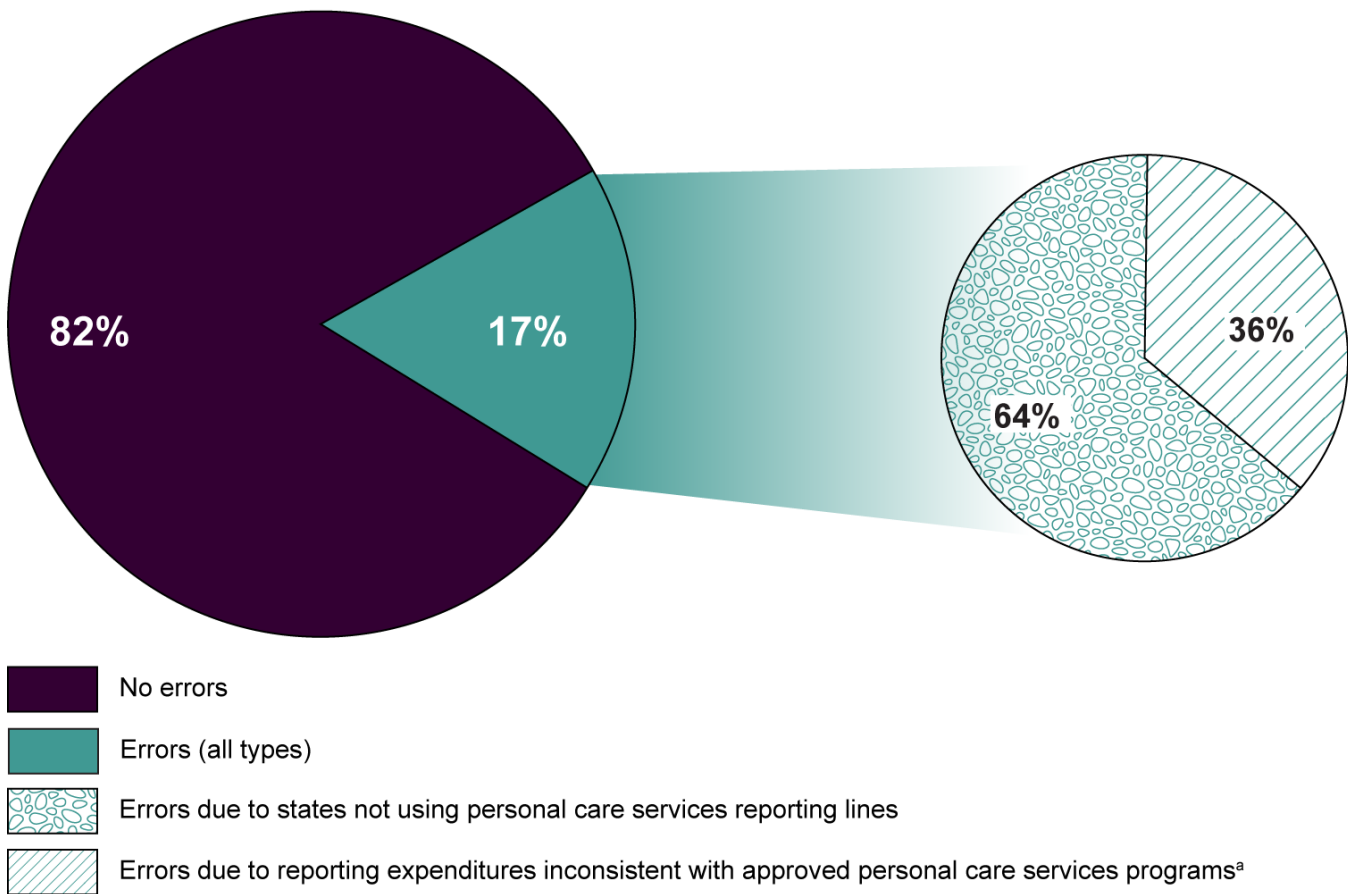
⁴⁰In addition to the 6 percent enhanced federal matching rate, states operating a Community First Choice program are subject to a maintenance of expenditures requirement—that is, states operating such a program are required in their first year to maintain or exceed the level of spending from the prior year.

⁴¹One of the two lines is for expenditures for personal care services provided under a Participant-Directed Option; the other is for services in which there is no Participant-Directed Option.

⁴²CMS’s annual expenditure report based on the MBES shows total spending for each of the three programs but does not include the subtotals for the specific types of services by which states are required to report their expenditures on the CMS-64.

erroneously reporting expenditures that did not correspond with approved programs. As a result, CMS is not able to efficiently and effectively identify and prevent states from receiving federal matching funds inappropriately, in part, because it does not have accurate fee-for-service claims data that track payments by personal care program type that is linked with expenditures reported for purpose of federal reimbursement.

Figure 11: Percentage of Personal Care Services Expenditure Lines in 2012 to 2015 with State Reporting Errors



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-169

Note: Data are for all 50 states and the District of Columbia.
^aErrors include states reporting personal care services expenditures for programs that they did not administer and states not reporting personal care services expenditures for programs that they did administer.

These errors demonstrate that CMS is not effectively ensuring its reporting requirements for personal care expenditures are met. By not ensuring that states are accurately reporting expenditures for personal care services, CMS is unable to accurately identify total expenditures for personal care services, expenditures by program, and changes over time. According to CMS, expenditures that states report through MBES are subject to a variance analysis, which identifies significant changes in reported expenditures from year to year. However, CMS's variance analysis did not identify any of the reporting errors that we found. CMS officials told us that they will continue to review states' quarterly expenditure reports for significant variances and follow up on such variances.

CMS is Taking Steps to Improve Data Collected from States, but Has Not Yet Fully Addressed Completeness, Consistency, and Accuracy of Personal Care Services Data

CMS has two ongoing actions intended to improve Medicaid claims data collected from states. First, CMS is developing an enhanced Medicaid claims data system—called the Transformed-Medicaid Statistical Information System (T-MSIS)—that will replace MSIS. Enhancements being made under T-MSIS include requiring states to report more timely data, additional claims information, and improved CMS checks on the quality of data submitted.⁴³ Specifically, states will be required to do the following, according to CMS:

- report data more frequently than they are now required (monthly rather than quarterly),
- submit a new data file reporting information on the providers of services, including provider identification numbers, and
- identify for each claim which expenditure line on the CMS-64 corresponds with the type of service covered by the claim.

⁴³Reporting a separate data file with provider information is not required under MSIS and, according to CMS, the number of data elements states are required to report under T-MSIS is nearly triple the number reported under MSIS.

CMS is also improving the quality of data reported by states by subjecting states' submitted data to thousands of electronic checks to identify obvious errors.⁴⁴

Despite the promise of T-MSIS, implementation has faced delays and is not yet complete. Implementation of T-MSIS by all states has been delayed for several years. The original date for nationwide implementation was January 2014; however, according to CMS officials, as of July 2016, 10 states were submitting T-MSIS data to CMS, but not all of the required data were submitted.⁴⁵ The agency expects that all states will be submitting T-MSIS claims data by the end of calendar year 2016. However, reaching this goal depends on the remaining states' timeliness in completing the work needed to successfully transmit the T-MSIS data. It could be a number of years before all states are submitting complete T-MSIS data that include all required data elements, according to officials.⁴⁶

Once all states are reporting T-MSIS claims data, including personal care services claims, key data limitations we identified associated with MSIS claims may not be fully addressed. This is because under T-MSIS, CMS has not taken steps to improve the completeness and consistency of personal care services claims data. For example, CMS has not issued guidance to establish:

- a uniform set of procedure codes to be used by all states to more consistently document type and quantity of personal care services rendered;
- state reporting requirements for provider identification numbers for personal care attendants.

⁴⁴According to CMS officials, T-MSIS includes approximately 3,500 automated quality checks, which provide states with immediate feedback on data format and consistency.

⁴⁵CMS requires states to submit a total of 8 T-MSIS data files. Under MSIS, CMS required states to report 5 data files. The 10 states are submitting all 8 files but some data elements may be missing in the files.

⁴⁶According to CMS officials, to complete their transition to T-MSIS, states must submit all eight data files to CMS. Some data elements may be missing in the data files and CMS will issue reports to the states identifying missing data elements.

-
- appropriate time periods covered by individual claims—that is, the maximum number of days that a personal care attendant may include in a single claim.

In addition, planned improvements in T-MSIS to identify the corresponding expenditure line on the CMS-64 may not be realized. CMS has stated a goal that T-MSIS would identify, for each claim paid in a fee-for-service delivery system, the expenditure line on the CMS-64 that corresponds with the type of service covered by the claim. This goal would allow better accounting for the claims paid and the services for which the claims were made. Further, this linking of the claims with the associated expenditure line could facilitate more accurate state reporting of expenditures on the CMS-64 and allow CMS to effectively reconcile each state's payments for personal care services with their reported expenditures. However, CMS's plans to have states link their T-MSIS claims with CMS-64 expenditure lines will be effective only for one personal care services program. For three other programs, T-MSIS claims are not required to be associated with a specific service type. Rather, the claims are identified simply as an HCBS service under one of the three programs. Without this information, T-MSIS claims for personal care services cannot be cross-walked with CMS-64 data on the expenditures for those services.⁴⁷

CMS's second ongoing action to improve Medicaid claims data collected from the states is the establishment of a new Division of Business and Data Analysis. This division is intended to help the agency ensure the quality of T-MSIS data. According to CMS officials, MSIS claims data have generally not been used for program monitoring and oversight, because issues with data timeliness, completeness, and consistency have limited their usefulness for these purposes. Development of T-MSIS is intended to address data issues and the establishment of the new

⁴⁷The three HCBS program types for which personal care services expenditures are separately reported from other types of HCBS services using feeder forms are the HCBS Waiver, State Plan HCBS, and Community First Choice programs. Based on the description by CMS officials of the link between T-MSIS claims and CMS-64 reporting lines, T-MSIS claims for personal care services under these three programs identify the applicable HCBS total line from the CMS-64, but do not specify the specific HCBS feeder forms for specific types of HCBS services, such as personal care services. For the fourth program (State Plan Personal Care Services), expenditures are reported directly on a single expenditure line because this program is solely for personal care services.

division is intended to facilitate the use of state-collected data by CMS. According to CMS officials, the new division is intended to:

- work with states to help ensure the completeness and consistency of claims data as states transition to T-MSIS,
- improve the quality of the data by analyzing the data for anomalies and errors that can be corrected,
- build the agency's capacity to use the data for program monitoring, oversight, and reporting, and
- provide data analysis support for different CMS program offices, including the offices that oversee states' personal care services programs.

According to CMS, the improved data will be used by CMS for program monitoring, policy implementation, improving beneficiary health care, and lowering costs. CMS efforts in building the agency's data analysis capacity are underway but in the early stages. Improving the quality of the data is a continuous process that depends on identifying specific data needed for oversight functions. According to CMS officials responsible for implementing T-MSIS, while T-MSIS has the capability for improving the quality of data submitted by states, policies and guidance are needed regarding how CMS will use it. CMS recognizes it has an important responsibility to support Medicaid agencies and leverage program data to protect the Medicaid program from fraud, waste, and abuse in part by improving the quality and consistency of Medicaid data reported to CMS and improving the analysis of this data to identify potential risks.⁴⁸

However, as of September 2016, neither the division nor the CMS offices responsible for managing different personal care services programs has identified or developed plans for analyzing and using personal care services data for program management and oversight, such as analytical tools and standard reports. Doing so could facilitate necessary changes to improve the quality of the data, clarify T-MSIS reporting requirements,

⁴⁸In its Comprehensive Medicaid Integrity Plan, CMS stated that it plans to increase the ability of state Medicaid agencies and CMS to leverage program data to protect Medicaid from fraud, waste, and abuse, in part by improving the quality and consistency of Medicaid data reported to CMS and improving the analysis of Medicaid program data to identify potential risks. See CMS, *Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018*. (Washington, D.C., 2014).

facilitate the integration of claims and expenditure data, and increase the usefulness of claims data for oversight.

Federal agencies should collect data that are reasonably free from error and bias, and represent what they purport to represent. Standards for Internal Control in the Federal Government indicate that appropriate data must be collected to enable program oversight and establish a strong internal control environment.⁴⁹ Timely, relevant, and reliable data are needed for decision making, external reporting, and monitoring program operations—for example, to conduct management functions such as tracking the growth in use of and spending on specific Medicaid services; to identify trends related to utilization and payments per service, provider, and beneficiary; and to identify areas at higher risk for fraud, waste, and abuse. Without complete and consistent federal data collected from states, CMS is unable to conduct effective oversight and perform key management functions specific to personal care services, such as ensuring that states report personal care services expenditures correctly; claims for enhanced federal matching funds are accurate, verifying states' historical spending levels for determining maintenance of expenditure requirements, linking payments from claims with reported expenditures, or providing technical assistance to states to identify improper personal care services payments.

Conclusions

Personal care services are an important Medicaid service for millions of vulnerable Medicaid beneficiaries. Federal and state spending on Medicaid home- and community-based services, including personal care services, has increased significantly in the last two decades and this growth is projected to continue. These services present high-risk payments for the Medicaid program and have one of the highest improper payment rates of all Medicaid services. In light of these factors, CMS needs complete and consistent information to effectively monitor and oversee these services, which it currently does not collect from states. We found that the data collected from states were often incomplete, inconsistent, or inaccurately reported. CMS's efforts to improve the quality and accuracy of the data collected from states have not resulted in guidance to states on reporting of personal care services data or plans for

⁴⁹ [GAO-14-704G](#).

using the data for oversight purposes. As a result, issues with the completeness, consistency, and accuracy of personal care services data reported by the states are likely to continue. With better data, CMS could more effectively perform key management functions related specifically to personal care services, such as ensuring that states' claims for enhanced federal matching funds are accurate and that maintenance of expenditure and cost neutrality requirements are met.

Recommendations for Executive Action

To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of and spending on Medicaid personal care services, we recommend CMS take the following four steps:

- Establish standard reporting guidance for personal care services collected through T-MSIS to ensure that key data reported by states, such as procedure codes, provider identification numbers, units of service, and dates of service, are complete and consistent;
- Better ensure, for all types of personal care services programs, that data on provision of personal care services and other HCBS services collected through T-MSIS claims can be specifically linked to the expenditure lines on the CMS-64 that correspond with those particular types of HCBS services;
- Better ensure that personal care services data collected from states through T-MSIS and MBES comply with CMS reporting requirements; and
- Develop plans for analyzing and using personal care services data for program management and oversight.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. HHS concurred with two of our four recommendations, specifically, that the agency better ensure that states comply with reporting requirements and develop plans for analyzing and using data. HHS did not explicitly agree or disagree with the two other recommendations—that the agency establish standard reporting guidance and improve the linkages between CMS-64 and T-MSIS data on personal care services. However, in its response to these two recommendations, HHS stated that the Department had recently published a request for information in the Federal Register intended to gather input on additional reforms and policy options to strengthen the integrity of service delivery and appropriate reporting standards for personal care services and other HCBS. HHS

indicated that the information collected will be used to determine the agency's next steps. In light of our findings of inconsistent and incomplete reporting of claims and encounters, errors in reporting expenditures, and the high risk of improper payments associated with personal care services, we believe that action in response to these two recommendations is needed to improve CMS oversight.

HHS also provided technical comments, which we incorporated as appropriate. HHS's comments are reprinted in appendix I.

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

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



Katherine M. Iritani
Director,
Health Care

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 15 2016

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: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services*" (GAO-17-169).

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

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
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: CMS NEEDS BETTER DATA TO MONITOR THE PROVISION OF AND SPENDING ON PERSONAL CARE SERVICES (GAO-17-169)

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 Personal Care Services (PCS). HHS takes the oversight of state PCS programs seriously and the health and well-being of Medicaid beneficiaries, particularly the most vulnerable, are a top HHS priority.

Medicaid PCS are services provided to eligible beneficiaries that allow them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. These services may be provided by an independent or agency-based personal care attendant (PCA). States can choose to furnish PCS through 1905 (a), 1915 (i), or 1915 (k) authorities, or through a home and community-based services (HCBS) waiver. As a result of these different statutory authorities that states may choose, PCS can vary greatly by state and within states, depending on the Medicaid authority used. However, states must request and receive approval from HHS to operate the programs and specify the services to be delivered. HHS has taken a number of steps to improve program coordination by issuing additional guidance, providing technical assistance to states and modernizing federal databases.

In January 2014, HHS promulgated final rules that harmonized many requirements for HCBS, including PCS. These regulations addressed beneficiary assessments and plans of care provisions for certain programs that provide PCS. The final rules for 1915(c) waivers also provided states with the option to combine coverage for multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers. It also allowed states to use a five-year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare.

More recently, HHS published guidance for providers summarizing PCS and PCA requirements, a brief explanation of differences between PCS and home health services, an overview of common causes of improper payments, and guidance on how to avoid them. HHS also recently issued an Informational Bulletin to states providing several options states could implement to secure a robust and qualified workforce to deliver home care services, including PCS. Options included the implementation of a registry to reflect individuals meeting the state's provider qualifications (or in the case of self-directed programs, meeting the beneficiary's qualifications) and the offering of basic training to workers without usurping beneficiary decisions on what skills are most appropriate for their homecare workers. In February 2016, HHS provided training for monitoring fraud, waste, and abuse in home and community-based settings for PCS.

HHS believes that maintaining state flexibility for this service, in terms of provider qualifications and oversight, is important. HHS plans to take additional steps to help develop policies for HCBS, including ways to advance program integrity while taking into account issues affecting beneficiary access. HHS has also incorporated a process to offer additional guidance to states for improving program integrity in the delivery of PCS and how they can help protect beneficiaries and taxpayers. GAO's recommendations and HHS' responses are below.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: CMS NEEDS BETTER DATA TO MONITOR THE PROVISION OF AND SPENDING ON PERSONAL CARE SERVICES (GAO-17-169)

GAO Recommendation

Establish standard reporting guidance for personal care services collected through T-MSIS to ensure that key data reported by states, such as procedure codes, provider identification numbers, units of services, and dates of services, are complete and consistent.

HHS Response

HHS currently has standard reporting requirements for T-MSIS codified in the T-MSIS data dictionary. In order to inform whether more specific reporting is necessary for PCS, HHS recently released a request for information (RFI) seeking input on additional reforms and policy options HHS could consider to accelerate the provision of HCBS to Medicaid beneficiaries and exploring areas that may be used to strengthen the integrity of service delivery. The RFI seeks input on feasibility and regulatory barriers for state Medicaid programs in trying to capture specific information, particularly the inclusion of home care worker identity at the individual staff level in a PCS agency on claims submitted for Medicaid reimbursement. HHS will review information and data in response to the RFI and will determine next steps with regard to appropriate reporting standards.

GAO Recommendation

Better ensure, for all types of personal care services programs, that data on the provision of personal care services and other HCBS services collected through T-MSIS claims can be specifically linked to the expenditure lines on the CMS 64 that correspond with those particular types of HCBS services.

HHS Response

While the capability exists to link T-MSIS claims and encounter data with categories of service on the CMS 64, it is important to clarify that the CMS 64 and T-MSIS are not inherently mirrored data sets. Both were designed for different purposes and as a result have different types of data categories with varying levels of required specificity. In addition, states submit data for each at different intervals. HHS is exploring comparisons of states' 64 data with their T-MSIS data to identify any disconnects, however the RFI HHS recently released will provide input on additional reforms and policy options that HHS could consider, which will inform whether additional policy guidance and direction on reporting in this area is necessary.

GAO Recommendation

Better ensure that personal care services data collected from states through T-MSIS and MBES comply with CMS reporting requirements.

HHS Response

HHS concurs with GAO's recommendation. HHS continually works with states to ensure compliance with the applicable HHS reporting requirements through T-MSIS and MBES. T-MSIS was designed with a number of front-end edits and back-end data quality checks to identify data anomalies and help ensure proper reporting by states. Should errors be identified

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: CMS NEEDS BETTER DATA TO MONITOR THE PROVISION OF AND SPENDING ON PERSONAL CARE SERVICES (GAO-17-169)

on T-MSIS and/or MBES reports, HHS will continue to work with the state to correct these errors for reconciliation.

GAO Recommendation

Develop plans for analyzing and using personal care services data for program management and oversight.

HHS Response

HHS concurs with GAO's recommendation and understands the importance of robust data and its subsequent use for program management and oversight. HHS is currently in the process of developing various tools to help data users analyze T-MSIS data, including PCS services. As part of this effort, HHS will review PCS data captured in T-MSIS and MBES and determine appropriate next steps for enhanced program management and oversight efforts.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact name above, Tim Bushfield, Assistant Director; Perry Parsons, Analyst-in-Charge; Anna Bonelli; Christine Davis; Barbara Hansen; Giselle Hicks; Laurie Pachter; Vikki Porter; Bryant Torres; and Jennifer Whitworth made key contributions to this report.

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