



January 2017

MEDICAID MANAGED CARE

Improved Oversight Needed of Payment Rates for Long-Term Services and Supports

Accessible Version

Why GAO Did This Study

The provision of long-term services and supports in Medicaid is a significant challenge, because of the vulnerability and service needs of beneficiaries, as well as the high cost of care. An increasing number of states have MLTSS programs, which can be used to expand community-based care and lower costs. However, whether these programs are an effective strategy depends, in part, on the design of the payment structures.

GAO was asked to review states' MLTSS payment structures and CMS's oversight. This report examines (1) how selected states structured their financial incentives, and (2) CMS policies and procedures for overseeing states' payment structures.

GAO reviewed relevant federal regulations, guidance, and internal control standards. For six states selected for variation in location and experience (AZ, DE, FL, KS, MN, and TX), GAO reviewed the contracts and rate certifications most recently approved by CMS, the terms and conditions set by CMS for the programs, and other payment documentation. GAO also interviewed CMS officials and Medicaid officials from the selected states.

What GAO Recommends

GAO recommends CMS (1) require all states to report on progress toward achieving MLTSS program goals, (2) establish criteria for what situations would warrant exceptions to federal standards for data used to set rates, and (3) provide guidance with minimum standards for validating encounter data. HHS concurred with GAO's recommendations.

View [GAO-17-145](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

MEDICAID MANAGED CARE

Improved Oversight Needed of Payment Rates for Long-Term Services and Supports

What GAO Found

Out of six states with Medicaid managed long-term services and supports (MLTSS) programs that GAO selected for review, five set clear financial incentives in their payment rates for managed care organizations (MCO) to provide care in the community versus in an institution. However, most of the selected states did not opt to link payments or penalties to MCO performance on MLTSS goals. These goals, which include enhancing the provision of community-based care, are developed by states and the Centers for Medicare & Medicaid Services (CMS), the agency in the Department of Health and Human Services (HHS) responsible for overseeing Medicaid.

GAO found that CMS's oversight of state payment structures was limited. CMS expects states' MLTSS programs to enhance the provision of community-based care. However, GAO found CMS does not consistently require states to report on whether the payment structures—including payment rates, incentive payments, and penalties—are achieving MLTSS goals. For example, CMS required three of the selected states to report on the provision of community-based care, but did not require any such reporting from the other three states. According to federal internal control standards, federal agencies should use quality information to achieve agency objectives. Without requiring information on states' progress toward MLTSS goals, CMS will continue to pay billions of dollars to states without knowing if states have sufficient incentives for community-based care.

In addition, GAO identified risks with CMS's oversight of the data used to set MLTSS rates, specifically the appropriateness and reliability of those data. Under federal regulations, MLTSS rates must be appropriate and adequate. To the extent that states use data that are not appropriate and reliable to set rates, the resulting rates could be too low, which could provide an incentive for MCOs to reduce care, or too high, which results in more federal spending than necessary.

- **Appropriateness concerns:** GAO found issues with the appropriateness of data used by two of the selected states. For example, one state used data from 2010 and 2011 to set rates for 2015. Beginning in July 2017, CMS will require rates to be based on the three most recent and complete years of data. Although CMS will allow exceptions, it has not specified criteria for what situations would warrant exceptions. Without specifying criteria, CMS's requirements may not sufficiently minimize the number of states using data of questionable appropriateness to set MLTSS rates.
- **Reliability concerns:** GAO and the HHS Office of Inspector General previously found evidence of reliability issues with managed care encounter data, which are the primary record of managed care services and a key source of data used to set MLTSS rates. In addition, GAO's review of state documentation indicated variation in selected states' procedures for validating the reliability of their encounter data, specifically the completeness and accuracy of the data. Beginning in July 2017, CMS will require states to validate encounter data, but CMS has not issued guidance with minimum standards for state procedures. Without minimum standards for state validation efforts, it is unclear that CMS's efforts will sufficiently minimize the risk of encounter data being incomplete or inaccurate.

Contents

Letter	1
Background	4
Most Selected States Set Incentives for Community-Based Care, but Did Not Link Payment to Performance on MLTSS Goals	14
CMS's Oversight of MLTSS Payment Structures Is Limited	19
Conclusions	28
Recommendations	29
Agency Comments and Our Evaluation	30

Appendix I: Characteristics of States' MLTSS Programs Selected for Our Review	31
Appendix II: Comments from the Department of Health and Human Services	34
Appendix III: GAO Contact and Staff Acknowledgments	37
Appendix IV: Accessible Data	38
Data Tables	38
Agency Comment Letter	40

Tables	
Table 1: Beneficiaries in Managed Long-Term Services and Supports Programs Receiving Community-Based Care in Selected States, 2013 and 2015	17
Table 2: Performance Measures and Financial Penalties in States' Managed Long-Term Services and Supports (MLTSS) Programs, 2015	19
Table 3: New Requirements Related to Data Used to Set Managed Care Rates, Centers for Medicare & Medicaid Services (CMS)	24
Table 4: Cost and Enrollment of Managed Long-Term Services and Supports (MLTSS) Programs for Selected States, 2015 ³²	
Table 5: Summary of Characteristics of Managed Long-Term Services and Supports (MLTSS) Programs in Selected States, 2015	33
Text for Figure 2: Managed Care Organizations' (MCO) Role in Developing Service Plans in Managed Long-Term Services and Supports (MLTSS) Programs	38

Text for Figure 3: Illustration of Financial Incentives in a Blended Rate for a Managed Care Organization (MCO) to Provide Community-Based Care	38
Text for Figure 4: Process for State Development and Centers for Medicare & Medicaid Services (CMS) Approval of Rates	39

Figures

Figure 1: States with Current or Planned Managed Long-Term Services and Supports (MLTSS) Programs, October 2016	6
Figure 2: Managed Care Organizations' (MCO) Role in Developing Service Plans in Managed Long-Term Services and Supports (MLTSS) Programs	8
Figure 3: Illustration of Financial Incentives in a Blended Rate for a Managed Care Organization (MCO) to Provide Community-Based Care	11
Figure 4: Process for State Development and Centers for Medicare & Medicaid Services (CMS) Approval of Rates	13

Abbreviations

CMS	Centers for Medicare & Medicaid Services
EQR	external quality review
FFS	fee-for-service
HHS	Department of Health and Human Services
MCO	managed care organization
MLTSS	managed long-term services and supports
OIG	Office of Inspector General

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January 9, 2017

The Honorable Charles E. Grassley United States Senate

The Honorable Orrin G. Hatch United States Senate

The Honorable Ron Wyden United States Senate

In Medicaid, long-term services and supports—which represent about a third of program spending—are designed to promote beneficiaries’ ability to live or work in the setting of their choice, which can be in the community or in an institution, such as a nursing facility.¹ For many beneficiaries, receiving care in the community is preferable, and services such as personal care services and adult day care may allow them to continue living in their homes.² Increasing the availability of community-based care is also important to states’ ability to comply with the Supreme Court’s 1999 decision in *Olmstead v. L.C.* in which the Court held that unjustified institutionalization of a person based on disability violates Title II of the Americans with Disabilities Act.³

States are increasingly providing long-term services and supports through managed care—referred to as managed long-term services and supports (MLTSS)—with over 500,000 beneficiaries.⁴ In MLTSS, managed care organizations (MCO) are responsible for providing a specific set of

¹Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of low-income people or persons with disabilities. Federal and state Medicaid spending under managed care and fee-for-service for long-term services and supports totaled over \$150 billion in fiscal year 2014. See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending* (Truven Health Analytics, 2016).

²Personal care services assist beneficiaries with activities of daily living, such as bathing, dressing, and toileting. Adult day care refers to a variety of services and activities provided in a group setting within the community.

³*Olmstead v. L.C.*, 527 U.S. 581 (1999). In particular, the Court held that states must provide community-based care for persons with disabilities who are otherwise entitled to institutional services when such services are appropriate, the individual does not oppose such treatment, and the community-based care can be reasonably accommodated, taking into account the resources available to a state and the needs of others with disabilities.

⁴States may have different types of managed care arrangements in Medicaid. In this report, where we refer to Medicaid managed care, we are referring to comprehensive, risk-based managed care, the most common type of managed care arrangement.

Medicaid-covered services to beneficiaries in return for a set payment per beneficiary per month, referred to as a capitated rate.⁵ MLTSS can be a strategy for states to expand the provision of community-based care, which means increasing the proportion of beneficiaries that receive care in the community versus an institution, and to deliver more integrated services, potentially at a lower cost.⁶ At the same time, the use of managed care assumes that the provision of appropriate services can be achieved in a cost-effective manner for a population that is among the most vulnerable and has particularly high health care needs. Beneficiaries who receive MLTSS are limited in their ability to care for themselves due to physical, developmental, or intellectual disabilities or conditions.

How states design their payment structures, including the structure for rates, incentive payments, and penalties, affects whether states will achieve program goals. MLTSS goals, including the goal to expand the provision of community-based services, are determined by the states and the Centers for Medicare & Medicaid Services (CMS), the federal agency in the Department of Health and Human Services (HHS) responsible for overseeing the Medicaid program. CMS guidance sets expectations for states seeking approval of their MLTSS programs. In particular, CMS expects states to design their rates to enhance the provision of community-based care.⁷ States are also required to set actuarially sound rates; that is, rates that have been certified by an actuary as being appropriate and adequate.⁸ In May 2016, CMS issued new rules for Medicaid managed care that could affect how states set rates for MLTSS programs and how CMS oversees such programs.⁹ Rates that are too low can raise concerns about quality and access, while rates that are too high

⁵For the remainder of the report, when we refer to rates, we are referring to capitated rates.

⁶States are required to cover institutional care as part of Medicaid, but coverage of most community-based care is optional.

⁷See Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (2013).

⁸Rates are to be appropriate for the populations and services covered, and rates are to be adequate for MCOs to meet requirements for ensuring availability and timely access to services, adequate networks, and coordination and continuity of care. See 42 C.F.R. §§ 438.4, 438.206, 438.207, 438.208 (2016).

⁹Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498 (May 6, 2016).

may mean that scarce Medicaid resources are diverted away from providing services to beneficiaries.

To better understand Medicaid MLTSS programs, you asked us to provide information about states' payment structures and other financial incentives, and CMS oversight of states' payment structures. In this report, we examine

1. how selected states structured the financial incentives in their MLTSS programs, and
2. CMS's policies and procedures for overseeing states' payment structures for MLTSS programs.

To examine how states structured the financial incentives in their MLTSS programs, we reviewed selected states' documentation of their payment structures—particularly information on their rate structures and other payments or penalties linked to performance—and relevant federal regulations and guidance. Given variation in states' MLTSS programs, we selected six states that provided a range in experience with MLTSS and were geographically diverse. We selected three states with over 5 years of experience with MLTSS—Arizona, Minnesota, and Texas—and three states with less than 5 years of experience—Delaware, Florida, and Kansas. Together, our selected states represented over 20 percent of MLTSS enrollment nationally as of July 2014, which is most recent national data available. (See app. I for more information on our selected states.) For our selected states, we reviewed the contracts between the states and their MCOs that were most recently approved as of December 2015; these contracts generally covered all or part of 2015.¹⁰ We also reviewed the most recently approved rate certifications submitted to CMS by our selected states as of December 2015; these certifications, which describe the rate structures, covered all or part of 2015. To supplement our review, we interviewed Medicaid officials from our selected states about the design of their rate structures and their other financial incentives, and we requested information from the states on financial penalties and methods for monitoring the effects of their payment structures. We also interviewed stakeholder groups, including the American Academy of Actuaries, about factors affecting financial incentives set by states.

¹⁰CMS reviews and approves states' contracts with MCOs, as well as rate certifications, for all managed care programs, including MLTSS programs.

To examine CMS's policies and procedures for overseeing states' payment structures, we reviewed relevant federal regulations and guidance. Specifically, we reviewed regulations governing managed care programs, rate setting guidance—referred to as rate guides—issued annually by CMS to states, and guidance on CMS's expectations for MLTSS programs. We also reviewed documentation from CMS's reviews of the rate certifications from our selected states, including questions raised by CMS during those reviews. Lastly, we reviewed the terms and conditions set by CMS and approved waiver applications for the MLTSS programs in our selected states, particularly provisions that related to reporting on progress toward program goals, such as enhancing the provision of community-based care. We assessed CMS's policies and procedures against actuarial soundness requirements in Medicaid managed care regulations and federal internal control standards.¹¹ To supplement our review, we interviewed CMS officials about the regulations and guidance, their process for reviewing states' rate certifications, and how their reviews align with their overall oversight of MLTSS programs.

We conducted this performance audit from August 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 findings and conclusions based on our audit objectives.

Background

An increasing number of states have chosen to offer MLTSS programs. As of October 2016, 21 states had MLTSS programs and 8 additional states had plans to implement MLTSS programs. (See fig. 1.) The most recent enrollment data available at the time of our study, from July 2014, showed that MLTSS programs in 17 states collectively served at least 500,000 beneficiaries, and 5 of those states served over 50,000

¹¹See 42 C.F.R. § 438.4 (2016) for actuarial soundness requirements. Also see GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014); and *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1, 1999).

beneficiaries each.¹² In fiscal year 2014, Medicaid spent an estimated \$22.5 billion on MLTSS.¹³

¹²See Centers for Medicare & Medicaid Services and Mathematica Policy Research, *Medicaid Managed Care Enrollment and Program Characteristics, 2014* (2016). CMS estimated that the number of total beneficiaries, as of July 2014, was between 500,000 and 1,680,000.

¹³See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*. Due to challenges with collecting MLTSS data, Truven Health Analytics reported that this is a conservative estimate of overall MLTSS expenditures.

disabilities. States may limit some of these populations to adults or may include both children and adults.

- **Flexibility in determining whether enrollment will be mandatory or voluntary.** Generally, states with mandatory enrollment can require beneficiaries to be in the MLTSS program, whereas states with voluntary enrollment offer beneficiaries a choice between the MLTSS program and receiving similar services through fee-for-service (FFS).¹⁴
- **Flexibility in the services included and the extent to which MLTSS is part of a comprehensive managed care program.** States can cover a variety of services, including community-based care and institutional care.¹⁵ In addition, some states choose to have MLTSS as part of a broader, comprehensive managed care program that also includes physical and behavioral health, while others have MLTSS as a separate managed care program.

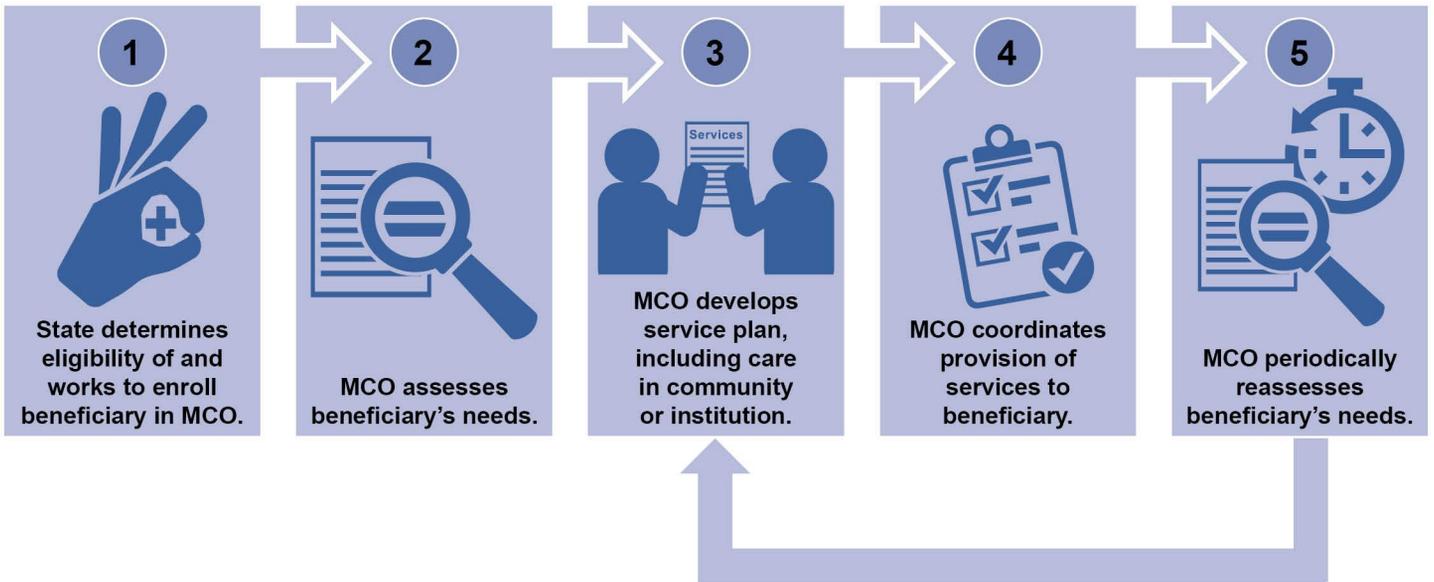
To be eligible for MLTSS, beneficiaries must meet income and asset requirements, and also meet state-established criteria on the level of care needed, such as needing an institutional level of care.¹⁶ Once a person is determined eligible by the state Medicaid agency, they can be enrolled in an MCO. The MCO then develops a service plan, which includes determining the types and amount of services expected to be needed by the beneficiary. (See fig. 2.) For example, for a beneficiary receiving care in the home, the MCO determines if personal care services are needed and, if so, the amount of services, such as the number of hours, needed per week.

¹⁴Under FFS, Medicaid pays providers for each service provided to a Medicaid beneficiary.

¹⁵For example, community-based care could include personal care services to assist beneficiaries with activities of daily living, such as bathing, dressing, and toileting; adult day care services and activities provided in a group setting within the community; certain home modifications that allow the beneficiary to remain in the home; and non-medical transportation. Institutional care could include care in nursing facilities and in intermediate care facilities for individuals with intellectual disabilities.

¹⁶To determine who meets criteria on level of care, states may use functional criteria (e.g., the extent to which a person needs assistance with activities of daily living), clinical criteria, or a combination of the two. Eligibility requirements also apply for long-term services and supports provided under FFS.

Figure 2: Managed Care Organizations’ (MCO) Role in Developing Service Plans in Managed Long-Term Services and Supports (MLTSS) Programs



- 1** The state, or an independent entity, determines eligibility and works with the beneficiary to enroll in an MCO. To be eligible for MLTSS, a beneficiary must meet state-established criteria on the level of care needed, such as needing an institutional level of care.
- 2** The MCO assesses the beneficiary's physical, functional, and psychosocial needs such as health status, treatment needs, and preferences for care. These also include social, employment, and transportation needs and preferences.
- 3** The MCO is responsible for developing/revising a service plan through a process that actively engages the beneficiary and individuals of choice. The service plan must address how a combination of covered services and available community supports will meet the beneficiary's or caregiver's needs and preferences, including preferences for receiving care in the community or in an institution..
- 4** The MCO coordinates the provision of all services to the beneficiary. Services may include MLTSS—both community-based and institutional services—as well as physical and behavioral health services.
- 5** The MCO reassesses the beneficiary's needs at least every 12 months, after a significant change in the beneficiary's needs or circumstances, or at the request of the beneficiary.

Source: GAO analysis of Centers for Medicare & Medicaid Services regulations and guidance. | GAO-17-145

Federal Approval of MLTSS Programs

States are required to seek CMS approval for their MLTSS programs, including their payment structures, which they can implement through several different authorities. Among the most commonly used authorities

are section 1115 demonstrations and section 1915(b) waivers.¹⁷ In CMS's 2013 guidance on its expectations for states' MLTSS programs using either of those two authorities, the guidance noted that states' programs should enhance the provision of community-based care.¹⁸ In addition, the guidance noted that, consistent with the intent of the Americans with Disabilities Act and the *Olmstead* decision, rate structures must encourage the delivery of community-based care, and other payments and penalties linked to performance must also support MLTSS program goals. Other program goals could include provision of supports to aid beneficiaries in achieving competitive employment, provision of services in the most integrated setting, and consumer satisfaction.

Before approving an MLTSS program under one of these authorities, CMS engages with states to shape the structure of the program, including alignment with CMS's 2013 guidance.¹⁹ For example, a state generally goes through a design phase during which the state engages in discussions with CMS. The state then submits a formal application to CMS, and the subsequent federal review process may include negotiations, including on the design of the payment structures. States with approved MLTSS programs are subject to reporting requirements, which could include financial reporting and quarterly and annual reports that provide CMS with information on the state's progress, but the exact reporting requirements may vary by state. For example, CMS may require some states to report on the number of beneficiaries served, expenditure data, information on grievances and appeals, or other requirements specific to the state.

¹⁷Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. Section 1915(b) provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. States that use section 1915(b) waivers to implement MLTSS programs may also have a concurrent, separate authority such as section 1915(c) waivers. Specifically, states use section 1915(b) waivers to mandate enrollment in managed care and use section 1915(c) waivers to target eligibility and provide certain community-based care in their MLTSS programs.

¹⁸See Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers*.

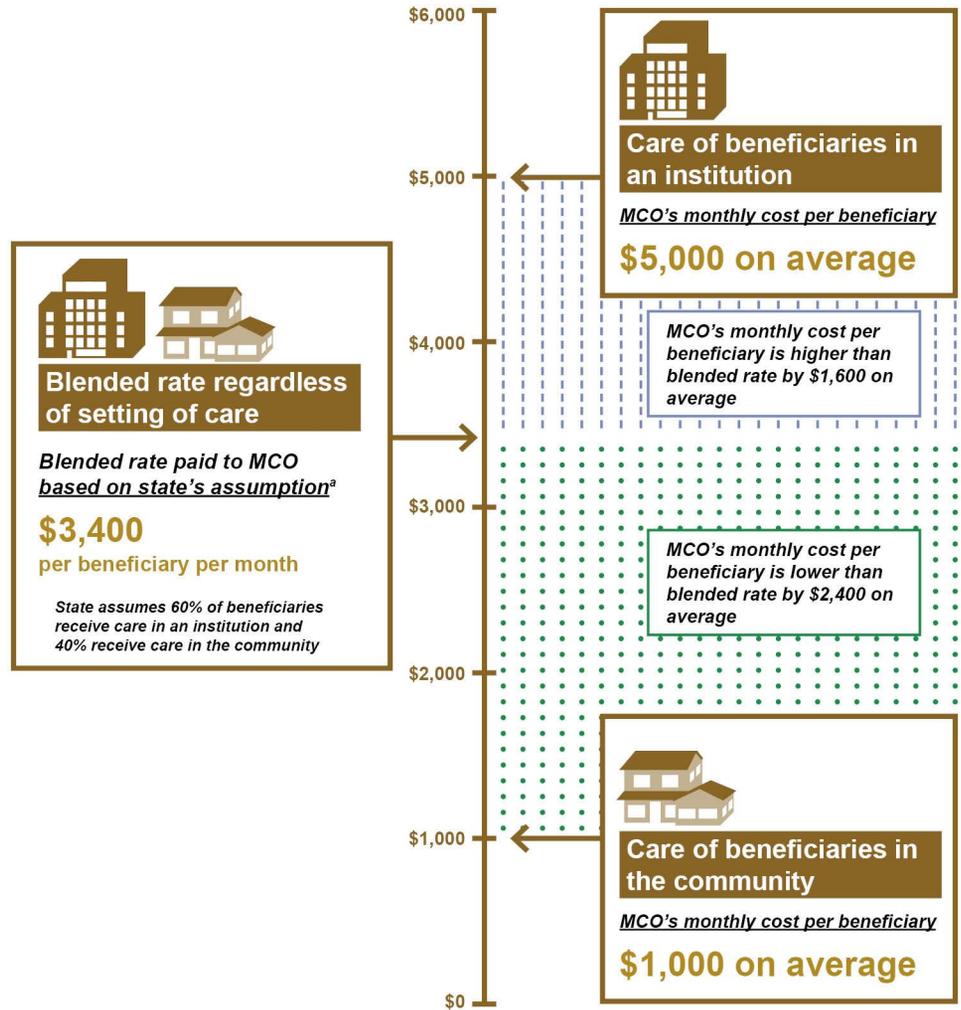
¹⁹CMS incorporated aspects of this guidance in its Medicaid managed care final rule, which was issued in May 2016.

Development and Approval of MLTSS Payment Structures

States take various approaches to designing their MLTSS payment structures—the structure of rates and of incentive payments and penalties—which can influence the financial incentives being set for MCOs. For the rate structures, for example, some states choose to set one rate for beneficiaries in the community and a different rate for beneficiaries in institutions. Other states may choose to set a single rate regardless of the beneficiary’s setting of care, which is known as a blended rate. States that use a blended rate intend for it to set a financial incentive for MCOs to provide community-based care, because of the generally lower cost of such care.²⁰ (See fig. 3.) In addition, states can also set incentives for MCOs’ performance by linking it to certain payments or penalties. For example, states can make a portion of payments conditional on achieving specified benchmarks. States can also impose financial penalties on MCOs for not fulfilling requirements in the contract, which may include requirements that relate to the quality of and access to care.

²⁰In its guidance, CMS described the blended rate as one way for states to set financial incentives for community-based care. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *2016 Medicaid Managed Care Rate Development Guide* (Baltimore, Md.: September 2015); and Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers*.

Figure 3: Illustration of Financial Incentives in a Blended Rate for a Managed Care Organization (MCO) to Provide Community-Based Care



Source: GAO. | GAO-17-145

³To determine the amount of the blended rate, a state calculates a weighted average of the costs of community-based care and institutional care. In this illustration, which reflects reasonable assumptions and costs in an MLTSS program, the blended rate is based on the state's assumption that 40 percent of beneficiaries would receive care in the community at an average monthly cost of \$1,000, and the other 60 percent would receive care in an institution at an average monthly cost of \$5,000. A state may also incorporate other costs and services, such as case management, into the rate paid to an MCO, but these costs and services are not shown.

By law, states must develop and get CMS approval of rates that are actuarially sound. Actuarially sound rates are projected as providing for all reasonable, appropriate, and attainable costs required of the MCO to fulfill the terms of its contract with the state, and must be developed in accordance with requirements for CMS's review and approval of rates.²¹

- In order to project costs, states rely on various data, such as data on demographic, health, and functional factors; the setting of care; and the scope of benefits. The sources and extent of these data, referred to as base data, vary by state. States require MCOs to provide encounter data (which are the primary record of services provided to beneficiaries in managed care), and states may also use financial data from the MCOs and claims data from the Medicaid FFS population.²²
- States and their actuaries project costs and set rates based on these data with adjustments and assumptions to account for missing, incomplete, or anomalous data; the extent to which covered populations and services are reflected in the data; changes in benefits and policies; and trends in utilization and prices of services.
- When setting or amending rates, states must submit an actuarial rate certification that explains how the rates were developed.²³ CMS expects the rate certification to provide sufficient detail, documentation, and transparency to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final rate. CMS reviews the rate certification for compliance with agency requirements, including the rate guide for that year. CMS may ask questions of the state until CMS can assess that the data, assumptions, and rate development were reasonable and meet generally accepted actuarial principles and practices, at which point CMS approves the rates for the state to pay to the MCOs.

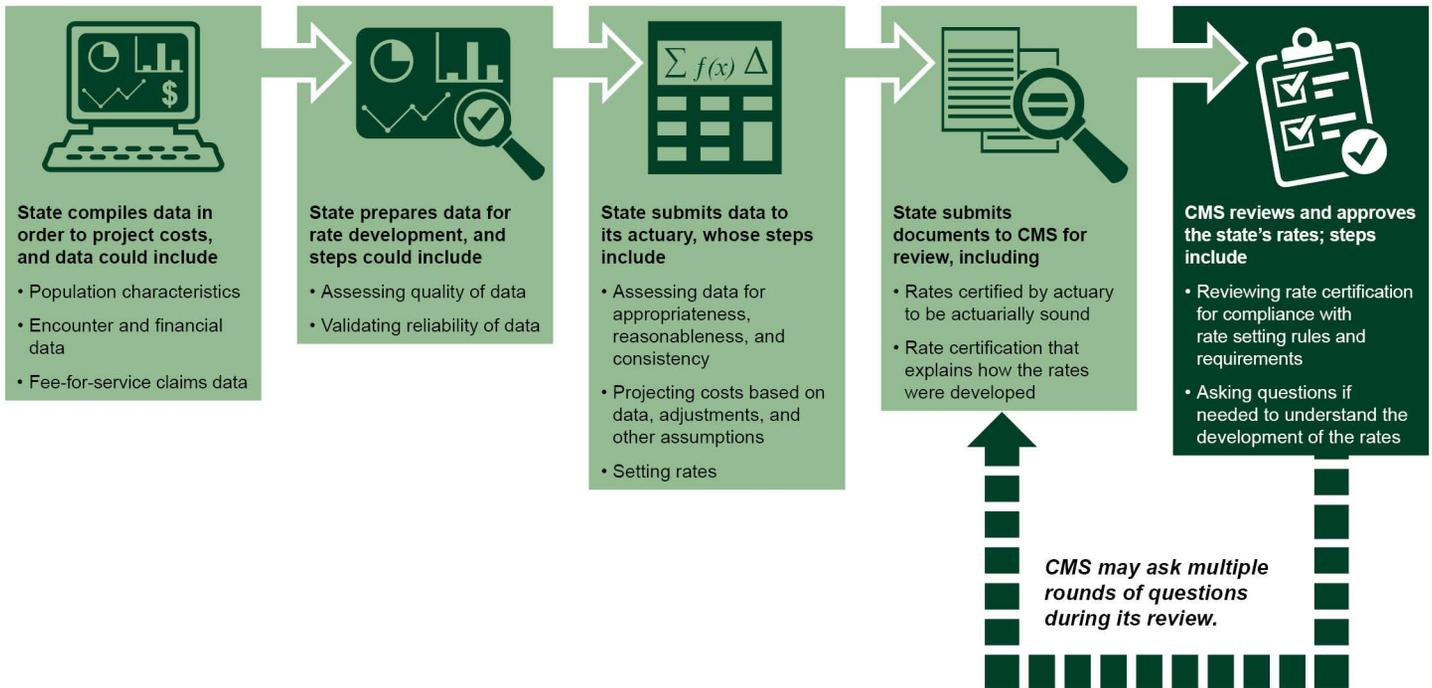
The different steps of the process undertaken by states to develop rates, and by CMS to approve rates, are illustrated in figure 4.

²¹See 42 C.F.R. § 438.4 (2016).

²²States are required to electronically submit encounter data to CMS quarterly.

²³States submit a single rate or a rate range for each given population. Some states use rate ranges to allow further negotiation with each MCO for a rate within that range.

Figure 4: Process for State Development and Centers for Medicare & Medicaid Services (CMS) Approval of Rates



Source: GAO analysis of CMS regulations and guidance and actuarial standards of practice. | GAO-17-145

CMS has made several changes to its review process in recent years. Beginning in January 2015, CMS added its Office of the Actuary as a reviewer of all rate certifications from states. In addition, CMS has made changes to its annually issued rate setting guidance, or rate guide, which is guidance issued to states on information that must be included in rate certifications. Specifically, the rate guide issued in 2015 for rates starting on or after January 2016 included a new section with additional considerations for setting MLTSS rates.²⁴ In May 2016, CMS issued a final rule that was the first major change to Medicaid managed care regulations since 2002, including the requirements around rate setting. The rate-setting requirements, such as CMS’s revised definition of actuarial soundness, became effective in July 2016, although certain provisions, such as those related to improving data reliability, apply on or after July 2017 or July 2018.

²⁴See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *2016 Medicaid Managed Care Rate Development Guide*.

Most Selected States Set Incentives for Community-Based Care, but Did Not Link Payment to Performance on MLTSS Goals

Five of our six selected states set financial incentives in their rate structures for providing community-based care, which is a CMS expectation for MLTSS programs. However, we also found that most of the six states did not opt to link payments to MCO performance on MLTSS program goals, such as enhancing the provision of community-based care.

Five of Six Selected States Set Financial Incentives for Providing Community-Based Care

Five of our six selected states set clear financial incentives in their rate structures for MCOs to provide community-based care. Specifically, for all or part of 2015, four of the states—Arizona, Delaware, Florida, and Kansas—used blended rates, where the state pays MCOs the same rate per beneficiary regardless of the setting of care. Blended rates are intended to set an incentive for community-based care, which generally has lower costs. The fifth state—Minnesota—used a modified version of a blended rate.²⁵ The four states with blended rates made different assumptions about the percentage of beneficiaries in community-based care when setting rates. These assumptions affected the strength of the financial incentive for community-based care. For example, for its rates ending in 2015, Florida assumed each MCO's percentage of beneficiaries receiving community-based care was 2 percentage points higher than the MCO's actual distribution in the previous year. Thus, Florida's rate was slightly lower than if the state used the MCO's actual distribution. The aggregate effect of that lower rate can be significant. For example, for one MCO with approximately 5,500 enrollees in Florida, we calculated that the difference of 2 percentage points in calculating the blended rate would result in approximately \$475,000 less per month. The other three states with blended rates did not use a fixed percentage increase in setting the assumptions for the blended rates. For example, Arizona

²⁵In its rates for calendar year 2015, Minnesota paid a "nursing facility add-on" for beneficiaries in the community to address the potential that the beneficiaries might need to move to an institution. MCOs then covered the higher cost of any institutional care out of the wider pool of payments, setting a financial incentive for community-based care.

officials said they tailored their assumptions to each MCO's past experience and the state's expectations about the MCO's capacity, and the assumptions could include making no increase.²⁶

For our sixth selected state—Texas—it was unclear if the rate structure set a financial incentive for community-based care. The state paid MCOs higher rates for beneficiaries receiving institutional care than for beneficiaries receiving community-based care.²⁷ The higher institutional rates could set an incentive for MCOs to move higher-cost beneficiaries from the community to an institution. Texas officials said that MCOs' greater ability to control community-based utilization and payments to providers gave them a financial incentive for community-based care. For example, whereas Texas MCOs must pay nursing facilities a specified rate, the MCOs may be able to negotiate lower rates with community-based providers, potentially lowering their costs compared to the rate received for community-based care.²⁸ CMS required the state to regularly report to CMS on the proportion of beneficiaries in community-based care to show whether or not there are changes in the proportion of such beneficiaries.

The selected states varied in their methods to account for the costs of beneficiaries with particularly high costs. These methods may have enhanced or reduced the incentives in the rate structure for community-based care.

- **Beneficiaries with high-cost institutional care.** In two of our selected states, the state (and not the MCOs) was responsible for covering certain costs of these beneficiaries. For example, Kansas excluded from MCO responsibility the cost for beneficiaries with intellectual or developmental disabilities in one of the state's public

²⁶Members of the American Academy of Actuaries said states must consider the capacity of community-based settings when setting the percentage of beneficiaries assumed to be receiving community-based care.

²⁷The higher institutional rates reflect the higher average cost of institutional care compared with community-based care. All rates were certified as actuarially sound.

²⁸The payment rates set by MCOs to community-based providers, such as home care workers, could have an impact on access to services. CMS issued an informational bulletin in August 2016 that encouraged states to be mindful of the relationship between access to care and wages for the Medicaid home care workforce. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce*, Center for Medicaid & CHIP Services Informational Bulletin (Baltimore, Md.: Aug. 3, 2016).

institutions. Minnesota excluded from MCO responsibility the cost of institutional care after 180 days. Instead, the states covered those costs through FFS, which could weaken the incentive for MCOs to manage those beneficiaries' care in such a way that keeps them from reaching those points.

- **Beneficiaries with high-cost community-based care.** Three of our selected states differed in how to cover certain costs of these beneficiaries. For example, Florida reimbursed MCOs for a percentage of costs of beneficiaries whose cost of community-based care exceeded the cost of equivalent institutional care.²⁹ Minnesota paid higher rates for beneficiaries who needed more assistance with activities of daily living and who were receiving community-based care. These provisions could counter incentives for MCOs to shift beneficiaries with a high cost of community-based care to institutions. Conversely, for example, Arizona required that if a beneficiary was projected to receive community-based care that exceeded the cost of equivalent institutional care, the beneficiary had to agree to move to institutional care or personally cover the additional costs of the community-based care. This could weaken the incentive for MCOs to manage care in such a way to reduce costs for beneficiaries at risk of hitting the cost ceiling, because those beneficiaries' costs are likely exceeding the rate paid to the MCO.

Data from four of our selected states—all of which had rate structures that set incentives for community-based care—indicated that the proportion of beneficiaries receiving such care increased between 2013 and 2015. As shown in table 1, state-reported data indicate that the percentage of community-based beneficiaries in Arizona, Delaware, Kansas, and Minnesota increased between 0.3 and 5.9 percentage points from 2013 to 2015. The two states with smaller increases included both an established program (Arizona, increase of 1.2 percentage points) and a newer program (Kansas, increase of 0.3 percentage points). The remaining two of our six selected states, Florida and Texas, had increases in the number of beneficiaries in community-based care, but, because of significant changes to their programs between 2013 and 2015, there were not comparable data to assess the difference in the percentage of beneficiaries receiving community-based care.

²⁹Florida withheld a certain percentage of the capitated payments to create a pool of funds, from which the reimbursements were drawn. Florida officials told us they created this pool of funds and reimbursements, because the beneficiaries with high-cost community-based care were disproportionately enrolled in certain MCOs.

Table 1: Beneficiaries in Managed Long-Term Services and Supports Programs Receiving Community-Based Care in Selected States, 2013 and 2015

State	2013 (percent)	2015 (percent)	Difference from 2013 to 2015 (percentage points)
Arizona	86.3	87.5	1.2
Delaware	46.4	52.4	5.9
Florida	^a	50.3	^a
Kansas	70.3	70.6	0.3
Minnesota	64.4	66.9	2.5
Texas	^a	55.1	^a

Source: GAO analysis of state-reported data. | GAO-17-145

Note: Data for Arizona, Delaware, Florida, and Kansas are as of December of each year. Data for Minnesota represent full-year equivalents based on reported member months for each calendar year, and data for Texas are average monthly enrollment for the calendar year.

^aComparable data were not available for Florida and Texas for 2013; therefore, we could not assess the difference in the percentage of beneficiaries receiving community-based care between 2013 and 2015.

Most Selected States Did Not Link Payments to Performance on MLTSS Goals

Most of our six selected states did not opt to link payments to MCOs' performance on MLTSS program goals, such as enhancing the provision of community-based care and aiding beneficiaries in achieving employment. In the contracts we reviewed, only one of our selected states (Kansas) linked payments to measures of outcomes on its MLTSS program goals. These measures included the rate of employment for certain beneficiaries receiving community-based care and the number of days of institutional care. In 2015, the state made 2 percent of the MCOs' payments—\$57.9 million for the three MCOs—conditional on the MCOs' performance on these and other measures, but, as of June 2016, the state had not yet determined the amounts to be returned to the MCOs based on their performance in that year. The remaining five selected states had no links between payments and MCOs' performance to measures of outcomes on MLTSS program goals. Instead, they mostly linked payments to measures of the outcomes or quality of care for beneficiaries' physical and behavioral health, but not the outcomes of the

long-term services and supports provided.³⁰ Officials from one state told us that they do not link payment to performance on MLTSS goals, because standardized measures for long-term services and supports are not available. In addition, federally led efforts to develop outcome measures for long-term services and supports are in the early stages.

In addition, most of our selected states had limited links between financial penalties and MCOs' performance. Although the contracts in all six of our selected states required MCOs to report on performance measures specific to MLTSS, among other areas, only Delaware's, Florida's, and Texas' contracts specified the amount of financial penalties, such as sanctions or damages, for MCOs that did not meet those performance measures. (See table 2.) For example, Florida could assess damages of \$500 per beneficiary dissatisfied with care management if the MCO failed to achieve a satisfaction rate of 90 percent or higher.³¹ As another example, Texas could assess damages of up to \$500 per beneficiary per day for late, inaccurate, or incomplete documentation of the MCOs' assessments of beneficiaries' needs. Data reported by our selected states indicated that the frequency of states issuing financial penalties varied, and when done were relatively small.³² In particular, three of our selected states issued no financial penalties or sanctions in 2015 for any reason.

³⁰Two states, Florida and Minnesota, also had measures related to MLTSS processes, such as the MCOs' documentation of their assessments of beneficiaries' needs, but no measures linked to MCO performance on the outcomes of the long-term services and supports provided.

³¹This performance measure was based on beneficiary survey results. It was included in Florida's contracts effective through June 2015, but not in contracts effective July 2015 and after.

³²With regard to imposing sanctions, generally, states describe a measured, hierarchical approach, starting first with corrective action plans and imposing more severe sanctions if the MCO does not come into compliance with the corrective action plan.

Table 2: Performance Measures and Financial Penalties in States’ Managed Long-Term Services and Supports (MLTSS) Programs, 2015

State	MLTSS performance measures	Contractual language on penalties, such as sanctions		Number of penalties	Total amount of penalties (dollars)	Average amount of penalty (dollars)
		Specified ability to impose sanctions for failure to meet measures	Specified amount of sanctions for failure to meet measures			
Arizona	Yes	Yes	No	16	588,370	36,773
Delaware	Yes	Yes	Yes	0	0	Not applicable
Florida	Yes	Yes	Yes	41	222,039	5,416
Kansas	Yes	Yes	No	0	0	Not applicable
Minnesota	Yes	No, but general ability to impose sanctions	No	0	0	Not applicable
Texas	Yes	Yes	Yes	214	1,830,934 ^a	8,556

Source: GAO analysis of state contracts and state-reported data. | GAO-17-145

Note: Penalties reported may not all be related to the performance measures. Delaware, Kansas, Minnesota, and Texas reported amounts for calendar year 2015; Arizona reported amounts by contract year ending in 2015; and Florida reported amounts for fiscal year 2015.

^aOf this amount, \$13,174 was not exclusive to Texas’ MLTSS program.

Our selected states also had different practices to monitor performance, particularly MCO decisions for beneficiaries’ service plans that detail the level and type of care to be provided. For example, officials from two states told us that they review and approve changes proposed by MCOs for beneficiaries’ service plans, such as reductions, suspensions, or terminations of services; and officials from four states told us that they required MCOs to submit data to the state on changes in the service plans. In addition, officials from five states told us they conduct audits or other types of reviews of the service plans. However, depending on the state, these reviews may use a sample of records or be targeted to a certain subset of beneficiaries. Officials in some states also told us that they track trends in grievances and appeals to assess beneficiaries’ satisfaction with MCO performance.

CMS’s Oversight of MLTSS Payment Structures Is Limited

We found weaknesses in CMS’s oversight of states’ payment structures. First, CMS has not consistently required states to report on progress toward MLTSS program goals, such as enhancing the provision of

community-based care, and therefore cannot assess the effectiveness of states' payment structures. Second, it is unclear whether new CMS requirements will sufficiently address issues with the appropriateness and reliability of the data used by states to set MLTSS rates.

CMS Does Little to Monitor State Progress toward MLTSS Program Goals, and the Effectiveness of CMS's Planned Efforts Is Unclear

CMS has not consistently required states to report data on whether their MLTSS payment structures are achieving MLTSS program goals, such as enhancing the provision of community-based care. For three of our selected states—Texas, Arizona, and Delaware—CMS required reporting on the provision of community-based care. For example, CMS required Texas to report regularly on the proportion of beneficiaries in community-based care as a way of monitoring whether the state's program set sufficient incentives for community-based care, since the state's rates were not clearly structured to encourage such care. CMS required Arizona to annually report on placements and activities for expanding community-based care. CMS required Delaware to assess rebalancing, i.e., the proportional shift from institutional to community-based care, as part of a long-term evaluation of the program.³³ For the three remaining states, CMS did not require reporting on progress toward goals to increase the use of community-based care.³⁴ Discussions with CMS officials confirmed that the agency has not consistently required states to report on progress toward MLTSS program goals.

Provisions in CMS's new managed care rule could provide an opportunity for more regular and standardized MLTSS data from states. The final rule requires states to submit annual reports on their managed care programs, including their MLTSS programs. The reports have to cover at least nine topic areas, such as the availability and accessibility of covered services

³³The state is required to submit a draft of the evaluation report to CMS within 120 days after the end of its section 1115 demonstration period.

³⁴Kansas, though not required during program approval, is measuring and reporting on improved integration of care through increased employment among beneficiaries in community-based care, the design of which was approved by CMS.

and the evaluation of MCO performance on quality measures.³⁵ The report must address MLTSS in covering these areas, but CMS did not require separate reporting of information related to MLTSS, unless there are factors in the delivery of MLTSS not addressed in the other areas. The deadline for the first report is contingent on CMS issuing guidance on the format and content of the reports. CMS officials said that they did not anticipate that this guidance would direct states to include additional MLTSS information, such as progress toward program goals. CMS officials told us that they do not plan to do so because the requirements should allow for state flexibility in reporting since these programs vary among states. However, CMS could require reporting while still allowing flexibility. For example, CMS could leverage performance measurement information that it is requiring all states to identify for MCOs providing MLTSS. Specifically, beginning in 2017, states must identify performance measures for MCOs on quality of life, rebalancing, and community integration activities, among other things.³⁶ States must require MCOs to measure and report on performance annually and submit the underlying data that would allow the state to assess performance on the measures. CMS officials told us that standardized MLTSS quality measures remain in the early stages of development; despite this, CMS could use preliminary information from states to inform potential concerns with program design within and across states.

CMS has two additional efforts that may provide it with new information from some states, but the information would be limited in scope and reliability, as shown below:

- **Expenditure data broken out by setting of care.** CMS officials told us that, beginning in April 2016, they began requiring states to break out managed care expenditures by setting of care in quarterly expenditure reports. This will allow CMS to calculate the proportion of MLTSS expenditures on community-based care versus institutional

³⁵See 42 C.F.R. § 438.66(e)(2) (2016). Other areas that states must cover in the annual report include financial performance of MCOs; encounter data reporting; modifications to, and implementation of, benefits covered under contracts with the state; grievances and appeals; an evaluation of MCO performance on quality measures; results of any sanctions or corrective action plans imposed on a contracted MCO; activities and performance of the beneficiary support system; and any other factors in the delivery of MLTSS not otherwise addressed.

³⁶See 42 C.F.R. § 438.330 (2016). States must require this comprehensive quality assessment and performance improvement program in all MCO contracts beginning on or after July 1, 2017.

care, which could serve as a proxy for assessing whether MLTSS programs are affecting the proportion of beneficiaries in each setting of care. CMS officials said that data limitations exist if using the data on a state-by-state basis, in part, because states are not required to certify the accuracy of the specific break out amounts of community-based care versus institutional care.

- **Standardized performance information from states with section 1115 demonstrations.** According to CMS officials, the agency plans to have states implementing MLTSS programs using section 1115 demonstrations report on certain standardized outcome measures, which as of November 2015, would include 12 of the 21 states with MLTSS programs. While some states are reporting some outcome information, CMS officials told us the agency wants to standardize the content and format of reporting requirements and data obtained.³⁷ As of September 2016, CMS officials said that they have not yet determined the measures that might be included in this effort or whether reporting will be mandatory or voluntary for states, and that CMS did not have target timeframes for beginning to collect the information.

According to federal internal control standards, federal agencies should use quality information to achieve their objectives.³⁸ Without consistently requiring information on state progress toward MLTSS goals, CMS will continue to approve programs and pay billions of dollars to states without knowing whether the payment structures are providing sufficient incentives for MCOs to provide community-based care.

CMS Has Established New Rate-Setting Requirements, but Risks Remain Regarding the Use of Appropriate and Reliable Data

CMS has established several new rate-setting requirements for states related to the data used to set rates, including MLTSS rates. (See table 3.) These requirements focus on the appropriateness and reliability of the data states use in rate setting, which are critical to whether the rates are

³⁷In addition, CMS has executed a contract for an evaluation of all section 1115 demonstration programs. The evaluation will also include MLTSS programs, including those operated under other program authorities. CMS officials told us they expect the interim report to be delivered in 2017.

³⁸See [GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

reasonable and adequate. In its annual rate development guide for 2016, CMS increased the information it required states to provide during rate review on the quality of the data used to set rates. CMS required states to describe the steps taken by their actuary and others to validate the data used to set rates. CMS specified that the information submitted needed to address the completeness, accuracy, and consistency of the data. CMS also specified that the state's actuary include their assessment of the quality of the data. In addition, under the final rule, the agency will begin to require states to meet additional standards for the appropriateness of the data used to set rates beginning in July 2017. The rule requires that states use base data that are no older than the three most recent and complete years prior to the rate year. These new regulations also require states to validate encounter data, which are the primary record of managed care services and a key source of data for setting managed care rates, and periodically audit those data, as well as financial data, which states also may use in rate setting.³⁹

³⁹For contracts beginning on or after July 5, 2016, the regulations also require states to submit all MCO contracts, including their rates, to CMS for approval no fewer than 90 days prior to the effective date of the contract, in order to provide CMS sufficient time to review rates before the beginning of the rate year. Some state officials had reported significant delays in CMS's approval of rates for 2015. As a result, at least two states were paying rates unapproved by CMS, though certified by the states' actuary. CMS officials attributed the 2015 delays to delays in receiving rate certifications from the states, delays in receiving responses from states to questions, and issues or errors found in rates during the review process. Delays were compounded, in part, by new review procedures, including having the CMS Office of the Actuary review the actuarial certifications, and CMS officials said that timeliness had improved for rates for 2016.

Table 3: New Requirements Related to Data Used to Set Managed Care Rates, Centers for Medicare & Medicaid Services (CMS)

Requirement	Source		Year applicable
	2016 rate guide ^a	Final rule ^b	
1. States must include a description of the steps taken by the actuary or others—including the state, managed care organizations (MCO), or other contractors—to validate the completeness, accuracy, and consistency of the data.	Included	Not Included	2016
2. States must provide a summary of the actuary's assessment of data.	Included	Not Included	2016
3. If encounter data are not used in rate development, states provide explanation as to why.	Included	Not Included	2016
4. States must use the most appropriate data to set rates, with the base data being no older than from the three most recent and complete years prior to the rating period, unless granted an exception by CMS. If granted an exception, states must develop a corrective action plan to come into compliance within 2 years.	Not Included	Included	2017
5. States must audit the accuracy, truthfulness, and completeness of the encounter and financial data submitted by MCOs at least once every 3 years.	Not Included	Included	2017
6. States must validate encounter data submitted by MCOs to the state to ensure that it is a complete and accurate representation of the services provided to beneficiaries.	Not Included	Included	2017
7. CMS will assess a state's submission of encounter data to determine if it complies with criteria for accuracy and completeness.	Not Included	Included	2018

Legend: **Included** = Source of requirement.

Source: GAO analysis of CMS guidance and regulations. | GAO-17-145

Note: Encounter data are the primary record of services provided to beneficiaries in managed care.

^aDepartment of Health and Human Services, Centers for Medicare & Medicaid Services, 2016 Medicaid Managed Care Rate Development Guide (Baltimore, Md.: September 2015). The guide pertains to rates on or after January 1, 2016.

^bSee 81 Fed. Reg. 27498 (May 6, 2016). Requirements 4, 5, and 6 apply to the rating period for contracts starting on or after July 1, 2017. Requirement 7 applies to contracts starting on or after July 1, 2018.

It is unclear, however, whether CMS's implementation of the new requirements will sufficiently minimize the risk of states using inappropriate and unreliable data to set MLTSS rates. Under federal regulations, in order to be actuarially sound, rates must be, among other things, appropriate for the population to be covered and services to be provided under a state's contract with an MCO, and adequate for the MCO to meet requirements to ensure timely access to services, adequate networks, and coordination and continuity of care.⁴⁰ To the extent that states are using data that are not appropriate or reliable, the data may not be a good predictor of expected costs, which could result in rates that are

⁴⁰See 42 C.F.R. §§ 438.4, 438.206, 438.207, 438.208 (2016).

too high or too low. Rates that are too high have implications for MCOs receiving more federal funding to care for beneficiaries than is necessary. Rates that are too low may create incentives for MCOs to reduce the level of care provided, affect the ability to attract providers, and affect the stability of the market. We found evidence of concerns with the appropriateness of data that states used to set rates and the reliability of such data.

Appropriateness of Data

In the rate certifications we reviewed and our interviews with state officials, we found evidence of concerns with the appropriateness of data used to set rates in two of our selected states:

- **State did not use recent data to set rates.** CMS approved rates for calendar year 2015 for one of our selected states, Delaware, which were developed using FFS data from 2010 and 2011. When reviewing the state's rate methodology, CMS questioned why the state did not use more recent data or a different type of data. The state explained that credible data from a more recent time period were not available at the time that the state developed its rates for calendar year 2015. Delaware's MLTSS program—established in 2012—was relatively new. In contrast, the other five states included 2013 or 2012 encounter data, as well as previous years of data in a couple of cases, to set their rates for all or part of 2015.
- **State did not rebase rates when newer data were available.** Officials in Arizona, a state with an MLTSS program that has been in place for over 20 years, told us that the state used the same years of base data to set the rates paid to MCOs within the 5-year contract period. Thus, by the fifth year, the base data used to set the rates would be over 5 years old.⁴¹ CMS officials told us that they were aware of Arizona's policy and that it was a concern that this state was not rebasing—using updated data to set rates—more frequently. They also said that they are aware of other states that rebase their rates infrequently, which officials attributed to the states lacking more recent, sufficiently reliable data for rate setting.

CMS has not determined the extent to which it will allow these two examples to continue under the new requirement that the data used to set rates be no older than the three most recent and complete years. Under

⁴¹Arizona officials told us they expect rebasing to occur more frequently going forward.

the new rule, a state that cannot fulfill this requirement would need to request from CMS an exception from the new data requirement. CMS officials told us that there can be circumstances where it is acceptable for states to use older data to set rates, such as during the first few years of implementing MLTSS programs and when the state has limited managed care experience. Similarly, CMS officials told us there may be instances in which a state would not rebase every year and states are not required to rebase annually. As of July 2016, CMS officials told us that they had not determined what situations would warrant exceptions from the new data requirements and did not know if they would issue guidance on the requirement.⁴² Without specifying its criteria for what situations would warrant exceptions, CMS may not be able to sufficiently minimize the number of states using data of questionable appropriateness to set rates.

Reliability of Data

We also found evidence of reliability issues with encounter data and of variation in state validation procedures.

- We and the HHS Office of Inspector General (OIG) have found evidence of reliability concerns with state encounter data. For example, in 2015, the OIG reported that 8 of 38 states reviewed did not report any encounter data for part of fiscal year 2011 to CMS by the required deadline.⁴³ The OIG also found that 11 states did not report required encounter data for all of their MCOs or other managed care entities, indicating a lack of completeness. Similarly, in 2015, we reported reliability issues with the encounter data, from calendar year 2010, reported by 6 states.⁴⁴
- Rate setting documents indicated variation in data validation efforts among our selected states. In the rate certifications we reviewed, one

⁴²CMS officials said they had not prioritized such guidance, because they had not received many questions on the requirement.

⁴³See Department of Health and Human Services, Office of Inspector General, *Not All States Reported Medicaid Managed Care Encounter Data as Required*, OEI-07-13-00120 (Washington, D.C.: July 2015).

⁴⁴One threshold we used to determine whether the data were unreliable was if fewer than 30 percent of beneficiaries used at least one service; this threshold was established by Mathematica for evaluating the completeness and usability of the data we analyzed. We also found that encounter data for 11 states were not available at the time of we began our review. See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, [GAO-15-481](#) (Washington, D.C.: May 29, 2015).

of our selected states (Arizona) described steps taken by the state Medicaid agency to validate the data used to set rates. Specifically, the rate certification for Arizona stated that the state Medicaid agency used encounter data validation studies, which included reviewing and auditing the data for accuracy, timeliness, and completeness, and compared the data to MCO financial statements. In the other five states, the rate certifications did not describe any validation procedures taken by the state Medicaid agency, which, under the actuarial standards of practice, is responsible for the accuracy and completeness of the data as the supplier of the data. Instead, the rate certifications described other steps taken by the actuary to check other aspects of the data, including reasonableness and consistency. In three of these states, the rate certifications also described steps taken by the actuary to compare the encounter data to other data sources.

While the new rule requires states to validate the completeness and accuracy of encounter data, CMS has not issued guidance with minimum standards for state data validation procedures and does not plan to do so. CMS officials noted that they had previously issued information to states on validation procedures, including a toolkit for states to use when establishing their encounter data systems and a data validation protocol that could be used as part of required external quality reviews (EQR).⁴⁵ CMS issued the encounter data toolkit, in part, because the agency recognized the importance of encounter data for setting rates, and that encounter data are only useful to the extent that they are complete and accurate. In the toolkit, CMS suggested that states need to check the data by conducting front-end edits of the data, as well as validating data through reports and setting benchmarks. Similarly, the EQR protocol on validating encounter data included detailed steps for a state to determine the validity—completeness and accuracy—of encounter data reported by MCOs. This protocol, however, is optional, and it is unclear whether it is being used by states.

Further, CMS may not receive complete information from states on their validation efforts, and, therefore, would not be able to assess whether state efforts are sufficient. CMS has required states to submit a description of validation efforts for 2016 rates, and its guidance indicates

⁴⁵See Mathematica Policy Research, *Encounter Data Toolkit* (Washington, D.C.: Nov. 30, 2013); and Department of Health and Human Services, Centers for Medicare & Medicaid Services, *EQR Protocol 4: Validation of Encounter Data Reported by the MCO* (September 2012).

that this should include steps taken by the actuary and others, including the state, MCOs, and external quality reviewers. However, CMS officials said that they expect that the information provided will likely focus on the work performed by the actuary, and may not include information on steps the state performed to validate the data submitted by MCOs. The new rule states that CMS will assess state encounter data submissions to ensure that the data meet criteria for accuracy and completeness, which may be another means for identifying certain weaknesses in states' validation efforts.

States' validation procedures are a critical check of the reliability of data for, among other purposes, setting rates. CMS has required states to set certain standards for enrollee encounter data in the states' contracts with their MCOs. However, required state validation checks are needed to ensure that these are consistently implemented by MCOs. Without minimum standards for such state validation efforts, it is unclear that those efforts will be sufficient to minimize the risk of encounter data being incomplete or inaccurate.

Conclusions

Using managed care to deliver long-term services and supports offers state Medicaid programs an important strategy that can encourage and enhance the provision of community-based care. Both states and CMS have the goal of enhancing the provision of community-based care, which many beneficiaries may prefer, and which can result in savings for states and the federal government. Achieving these goals depends, in part, on states establishing payment structures that align financial incentives for MCOs with those goals, and setting rates that are adequate and appropriate. CMS plays an important role in overseeing states' payment structures, both by monitoring whether states' payment structures are achieving Medicaid program goals, including enhancing the provision of community-based care, and assessing whether states' rates comply with actuarial soundness requirements.

CMS's new requirements under the May 2016 rule have created an opportunity for enhanced federal visibility over the effectiveness of MLTSS programs, which serve some of the most vulnerable Medicaid beneficiaries. For example, the requirements for annual reports on states' managed care programs and for states to identify MLTSS measures and require MCOs to report on them, if connected during implementation, could provide CMS with timely information on progress toward program

goals within a given state and nationally. Federal oversight is critical given our findings that states were often not linking payment to MCO performance on MLTSS goals. Without requiring all states to report on progress toward program goals, CMS will continue to pay billions of dollars for state programs without knowing whether they provide sufficient financial incentives for providing community-based care, which has implications both for beneficiaries and on federal costs.

CMS has taken a number of important steps to improve state rate-setting practices, including rates for MLTSS programs. Requirements under the new 2016 managed care rule, particularly the new data standards and validation requirements for encounter data, have the potential to better ensure that states are using appropriate and reliable data to set the rates paid to MCOs. However, CMS has not established criteria for what situations would warrant exceptions to the data standards, and has no plans to do so. Without clear criteria, states may continue to seek approval for rates that are based on data of questionable appropriateness, as was the case in Arizona and Delaware. With regard to encounter data validation requirements, CMS does not plan to issue any guidance or require minimum standards for state procedures, despite a history of data reliability concerns and lack of state compliance with reporting requirements. Without strong data, states and the federal government risk paying rates that are too low, which could result in quality and access concerns for beneficiaries, or rates that are too high, which diverts limited Medicaid dollars to MCO profit and away from needed care.

Recommendations

To improve oversight of states' payment structures for MLTSS, we recommend that the Administrator of CMS take the following three actions:

1. Require all states to collect and report on progress toward achieving MLTSS program goals, such as whether the program enhances the provision of community-based care.
2. Establish criteria for what situations would warrant exceptions to the federal standards that the data used to set rates be no older than the three most recent and complete years.
3. Provide states with guidance that includes minimum standards for encounter data validation procedures.

Agency Comments and Our Evaluation

We provided a draft of this product to HHS for comment. In its written comments, reproduced in appendix II, HHS concurred with our three recommendations and indicated steps HHS would consider taking in response. In response to our first recommendation to require all states to collect and report on progress toward achieving MLTSS program goals, HHS said it intends to release guidance clarifying the format of the annual reports on states' managed care programs so that it includes the results of the states' review of performance measures on quality of life, rebalancing, and community integration activities, among other things. In response to our second recommendation to establish criteria for what situations would warrant exceptions to the federal standards that the data used to set rates be no older than the three most recent and complete years, HHS said it will consider whether additional clarifying guidance is needed. In response to our third recommendation to provide states with guidance that includes minimum standards for encounter data validation procedures, HHS said it will work toward developing additional guidance on standards as it relates to encounter data validation procedures. HHS also provided technical comments, which we incorporated as appropriate. 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 appropriate congressional committees, the Secretary of Health and Human Services, and the Administrator of the Centers for Medicare & Medicaid Services. 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 yocomc@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 major contributions to this report are listed in appendix III.



Carolyn L. Yocom
Director, Health Care

Appendix I: Characteristics of States' MLTSS Programs Selected for Our Review

Our six selected states (Arizona, Delaware, Florida, Kansas, Minnesota, and Texas) have managed long-term services and supports (MLTSS) programs that varied in terms of cost and enrollment. In 2015, total capitated payments to managed care organizations (MCO) for MLTSS reported by the six states ranged from \$438.9 million for Delaware to \$3.7 billion for Florida. (See table 4.) The number of beneficiaries reported by each state also varied, ranging from 6,340 in Delaware to almost 98,000 in Texas.¹ In all of the selected states, these beneficiaries included seniors and adults with physical disabilities. In some of the selected states, these beneficiaries also included adults with intellectual and developmental disabilities and children with disabilities. The number of beneficiaries in some programs has changed in recent years. Specifically, between 2013 and 2015, two states—Florida and Texas—increased the number of beneficiaries by nearly 90 percent and over 145 percent, respectively, due to expansions in the scope of their MLTSS programs. Florida's program became statewide in 2014, while Texas' program expanded to rural areas in 2014 and began including beneficiaries receiving institutional care in its program in 2015.

¹To be eligible for MLTSS, beneficiaries must meet income and asset requirements, and also meet state-established criteria on the level of care needed, such as needing an institutional level of care.

Appendix I: Characteristics of States' MLTSS Programs Selected for Our Review

Table 4: Cost and Enrollment of Managed Long-Term Services and Supports (MLTSS) Programs for Selected States, 2015

State	Total capitated payments to managed care organizations for beneficiaries receiving MLTSS (dollars in millions)	Number of beneficiaries receiving MLTSS	Types of beneficiaries receiving MLTSS				Example of differences in services
			Seniors	Adults with physical disabilities	Adults with intellectual and developmental disabilities	Children with disabilities	
Arizona	1,570.3	55,475	Included	Included	Included	Included	Limit on cost of community-based care
Delaware	438.9	6,340	Included	Included	Not Included	Included	Exclusion of dental services
Florida	3,681.1	90,841	Included	Included	Included	Included (age 18-20)	Exclusion of physical health services, such as acute care
Kansas	1,272.6	33,255	Included	Included	Included	Included	Exclusion of public institutional care for people with intellectual and developmental disabilities
Minnesota	636.0	33,185	Included	Included (over age 65)	Included (over age 65)	Not Included	Exclusion of institutional care after 180 days
Texas	3,591.0	97,914	Included	Included	Not Included	Included	Inclusion of physical health services such as acute care (but not MLTSS) for adults with intellectual and developmental disabilities

Legend: **Included** = Included in program.

Source: GAO analysis of state-reported data. | GAO-17-145

Note: Data on payments are for calendar year 2015 for all states except for Arizona, which uses the federal fiscal year for one program and the state fiscal year for its other program. Data on beneficiaries for Arizona, Delaware, Florida, and Kansas are as of December 2015. Data on beneficiaries for Minnesota represent full-year equivalents based on member months for calendar year 2015. Data on beneficiaries for Texas represent average monthly enrollment for calendar year 2015.

The MLTSS programs in our selected states also varied across a number of other characteristics, such as age, number of MCOs participating, and length of contract period. (See table 5.)

**Appendix I: Characteristics of States' MLTSS
Programs Selected for Our Review**

Table 5: Summary of Characteristics of Managed Long-Term Services and Supports (MLTSS) Programs in Selected States, 2015

State	Program start year	Current program authority	Number of managed care organizations (MCO) under contract	Contract period
Arizona	1989	Section 1115 demonstration	Three MCOs One state agency	5 years with MCOs 1 year with state agency
Delaware	2012	Section 1115 demonstration	Two MCOs	3 years plus two option years
Florida	2013 ^a	Section 1915(b)/(c) waiver	Six MCOs	5 years
Kansas	2013	Section 1115 demonstration with section 1915(c) waivers	Three MCOs	3 years plus two option years
Minnesota	1997 and 2005 (two programs)	Section 1915(a)/(c) and section 1915(b)/(c) waivers	Seven MCOs	1 year
Texas	1998	Section 1115 demonstration	Five MCOs	3 years plus five option years

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) program approvals and state contracts. | GAO-17-145

^aFlorida previously had a smaller MLTSS program that ran from 1998 to 2014.

Appendix II: 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 13 2016

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

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports*" (GAO-17-145).

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: MEDICAID MANAGED CARE: IMPROVED OVERSIGHT NEEDED OF PAYMENT RATES FOR LONG-TERM SERVICES AND SUPPORTS (GAO-17-145)

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 managed long-term services and supports (MLTSS) programs. HHS takes seriously its effort to oversee states' MLTSS payment structures.

MLTSS offers states a broad and flexible set of program design options, and may be used as a mechanism for expanding home- and community-based services, promoting community inclusion, ensuring quality, and increasing efficiency. States can implement MLTSS using an array of managed care authorities, including a 1915(a) voluntary program, a 1932(a) state plan amendment, a 1915(b) waiver, or a section 1115 demonstration. States are increasingly incorporating populations and services that have long been excluded from capitated managed care arrangements into these models of care. Providing more integrated care for populations such as those who are dually eligible for Medicare and Medicaid, and coordinating acute care with long term services and supports hold the promise of delivering better care at lower costs.

Recognizing this shift in delivery system design and wanting to maximize the positive experience of beneficiaries as they make the transition to more integrated service models, HHS has provided guidance to states on the implementation of MLTSS programs. This includes guidance issued by HHS in May 2013 that provided ten key principles inherent in a strong MLTSS program, including requiring states to design their payment structures so that they support the goals of their MLTSS programs and the essential elements of MLTSS. On an ongoing basis, states must evaluate their payment structures and make changes necessary to support the goals of their programs.

In May 2016, HHS issued a final rule for Medicaid managed care (81 FR 27497) which encourages states to include payment methodologies that reflect the goals of MLTSS programs to improve the health of populations, support beneficiaries' experience of care, support community integration of enrollees, and control costs.

Lastly, in an effort to continually enhance the availability and quality of the MLTSS program, HHS has developed a number of technical assistance tools for states and other stakeholders. These can be found at: <https://www.medicaid.gov/medicaid/managed-care/lts/index.html>.

GAO's recommendations and HHS' responses are below.

GAO Recommendation

Require all states to collect and report on progress toward achieving MLTSS program goals, such as whether the program enhances the provision of community-based care.

HHS Response

HHS concurs with this recommendation. The managed care final rule requires states to identify standard MLTSS performance measures no later than the rating period for contracts starting on or after July 1, 2017 on quality of life, rebalancing, and community integration activities. Under

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID MANAGED CARE: IMPROVED OVERSIGHT NEEDED OF PAYMENT RATES FOR LONG-TERM SERVICES AND SUPPORTS (GAO-17-145)

the final rule, the state must require managed care plans that provide MLTSS to include in their quality assessment and performance improvement (QAPI) programs measures that assess the quality of life of beneficiaries and outcomes of the plan's rebalancing and community integration activities for those receiving MLTSS. HHS intends to release guidance clarifying the format of state monitoring reports as part of the final rule so that it includes the results of this performance measurement and review. Additionally, section 1115 evaluation efforts are under way to identify monitoring metrics and reporting requirements appropriate for 1115 demonstrations on MLTSS to support a more complete understanding of the beneficiary experience, use of services, health outcomes, and to help inform states in developing and reporting data about whether MLTSS program goals are being achieved.

GAO Recommendation

Establish criteria for what situations would warrant exceptions to the federal standards that the data used to set rates be no older than the 3 most recent and complete years.

HHS Response

HHS concurs with this recommendation. Data used to set rates must meet actuarial standards for data quality. The managed care final rule requires states to use the most appropriate data that is no older than from the 3 most recent years, derived from the Medicaid population, or adjusted to make the data comparable to the Medicaid population, and in accordance with actuarial standards for data quality. The rule permits HHS to grant an exception to states that seek approval to use data that is not from the 3 most recent and complete years, and states must make a written request that explains why the regulation standard cannot be met and includes a corrective action plan to remedy the situation. HHS will consider whether additional guidance clarifying this is necessary.

GAO Recommendation

Provide states with guidance that includes minimum standards for encounter data validation procedures.

HHS Response

HHS concurs with this recommendation. While HHS has developed a number of technical assistance tools around encounter data validation procedures, including External Quality Review Organization (EQRO) protocols describing the process for validating encounter data, HHS will work toward developing additional guidance on standards as it relates to encounter data validation procedures.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Corissa Kiyon-Fukumoto (Analyst-in-Charge), and Jessica L. Preston made key contributions to this report. Also contributing were Emei Li, Drew Long, Vikki Porter, and Jennifer Whitworth.

Appendix IV: Accessible Data

Data Tables

Text for Figure 2: Managed Care Organizations' (MCO) Role in Developing Service Plans in Managed Long-Term Services and Supports (MLTSS) Programs

Flow diagram showing the role of the MCO.

1. The state, or an independent entity, determines the eligibility of the beneficiary and works with the beneficiary to enroll in an MCO. To be eligible for LTSS, beneficiaries must meet a nursing facility level of care or other state-established criteria.
2. The MCO assesses the beneficiary's physical, functional, and psychosocial needs such as health status, treatment needs, and preferences for care. These also include social, employment, and transportation needs and preferences.
3. The MCO actively engages the beneficiary to develop/revise a service plan. The service plan addresses how a combination of covered services and available community supports will meet the beneficiary's or caregiver's needs and preferences.
4. The MCO provides or coordinates the provision of all services to the beneficiary. Services include physical and behavioral health services, as well as institutional and non-institutional LTSS.
5. The MCO reassesses the beneficiary's needs at least every 12 months, after a significant change in the beneficiary's needs or circumstances, or at the request of the beneficiary.

Source: GAO analysis of Centers for Medicare & Medicaid guidance.

Text for Figure 3: Illustration of Financial Incentives in a Blended Rate for a Managed Care Organization (MCO) to Provide Community-Based Care

- Illustration conveying message that less expensive care can be obtained when the enrollee is part of community based care, compared to higher costs for institutional care.
- MCO monthly cost for care in an institution is approximately \$5,000
- MCO monthly cost for care in the community is approximately \$1,000
- Blended rate paid to MCO based on State's assumption, regardless of setting is approximately \$3,400

Text for Figure 4: Process for State Development and Centers for Medicare & Medicaid Services (CMS) Approval of Rates

- 1) State compiles data in order to project costs, data could include,
 - a) population characteristics,
 - b) encounter and financial data,
 - c) fee for service claims data.
- 2) State prepares data for rate development and steps could include,
 - a) accessing quality of data,
 - b) validating reliability of data.
- 3) State submits data to it's actuary, whose steps include,
 - a) Assessing data for appropriateness, reasonableness and consistency,
 - b) Projecting costs based on other assumptions,
 - c) setting rates.
- 4) State submits documents to CMS for review to include, 1) rates certified by actuary are actuarially sound, 2) rate certification hat explains how rates were developed.
- 5) CMS reviews and approves the state's rates. Steps include:
 - a) Reviewing rate certification for compliance with rate setting rules and requirements,
 - b) Asking questions if needed to understand the development of rates (which might involve multiple rounds of questions).

Agency Comment Letter

Text of Appendix II: Comments from the Department of Health and Human Services

Page 1

Carolyn Yocom

Director, Health Care

U.S. Government Accountability Office

441 G Street NW Washington, DC 20548

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Jim R. Esquea

Assistant Secretary for Legislation

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Page 2

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Page 3

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