



January 2017

# MEDICAID

## Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements

Accessible Version

# GAO Highlights

Highlights of [GAO-17-173](#), a report to congressional requesters

## Why GAO Did This Study

To inform its oversight of Medicaid, CMS relies on state-reported data that contain information on multiple aspects of the program, including expenditures and service utilization. Recent increases in Medicaid improper payments, which were an estimated \$36 billion in fiscal year 2016, have exacerbated concerns about the quality of data available to CMS for program oversight.

GAO was asked to examine the usefulness of Medicaid data for oversight purposes and any efforts to improve known limitations. This report (1) describes how available Medicaid expenditure and utilization data affect CMS's ability to oversee the Medicaid program; and (2) examines CMS's efforts to improve these data. To address these objectives, GAO reviewed agency guidance, laws, regulations, and federal internal control standards; reviewed reports from GAO and others published from March 2010 through September 2016; and interviewed CMS officials about continuing data challenges and initiatives to improve data.

## What GAO Recommends

GAO recommends that CMS take immediate steps to improve Medicaid data available for program oversight, such as expediting efforts to assess and ensure the quality of T-MSIS data. HHS concurred with GAO's recommendation.

View [GAO-17-173](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

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# Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements

## What GAO Found

GAO found that available Medicaid expenditure and utilization data do not provide CMS with sufficient information to consistently ensure that payments are proper or that beneficiaries have access to covered services. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers the Medicaid program, relies on two key data sources for program oversight: the CMS-64, which serves as the basis for calculating the amount of federal matching funds for states, and the Medicaid Statistical Information System (MSIS), which is designed to report individual beneficiary claims data. The CMS-64 and MSIS have the potential to offer a robust view of payments, overall spending, and services in the Medicaid program; however, GAO found that the usefulness of these data is limited because of issues with completeness, accuracy, and timeliness.

- Available expenditure data do not provide complete or accurate information on how states finance their portion of program costs, such as complete data on the sources or amounts of local government funds used to finance states' share of Medicaid costs, thus complicating CMS's ability to assess the appropriateness of states' financing.
- Available utilization data, particularly for Medicaid managed care, are incomplete and are reported up to 3 years late, complicating CMS's ability to identify billing patterns that indicate inappropriate provider behavior or ensure that beneficiaries have access to covered services.

CMS has acknowledged the need for improved Medicaid data and cites the Transformed Medicaid Statistical Information System (T-MSIS) as its key initiative to improve Medicaid data and program oversight. T-MSIS includes aspects aimed at improving the completeness, accuracy, and timeliness of state data available to CMS, yet uncertainty remains as to when these data will be available from all states as implementation has been delayed for several years. As of October 2016, 18 states were submitting T-MSIS data. Although CMS officials were uncertain when the remaining states would begin submitting data, they estimated that states representing over 70 percent of the Medicaid population would be submitting T-MSIS data by the end of calendar year 2016. CMS officials identified several factors contributing to states' delayed T-MSIS implementation, such as coinciding with the ongoing efforts of over 30 states to redesign or replace their Medicaid information technology systems. Moreover, CMS has not fully developed its plans to ensure the quality of T-MSIS data, and its plans for using these data for oversight purposes remain preliminary. Through rulemaking and other guidance, CMS has taken other actions to improve data; however, given that these actions have recently or not yet been implemented, it is unclear how they will affect CMS's oversight. CMS's continued reliance on inaccurate, incomplete, and untimely data, and the ongoing uncertainty about the scope and timing of its remedial actions, hamper effective oversight and are inconsistent with federal internal control standards, which require entities to rely on quality and timely information to oversee their programs and take timely actions to improve deficiencies.

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CHIP	State Children's Health Insurance Program	
CMS	Centers for Medicare & Medicaid Services	
CRS	Congressional Research Service	
DSH	Disproportionate Share Hospital	
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment	
FFS	fee-for-service	
FMAP	Federal Medical Assistance Percentage	

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HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services' Office of Inspector General
MAX	Medicaid Analytic eXtract
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	managed care organization
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
T-MSIS	Transformed Medicaid Statistical Information System
UPL	upper payment limit

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January 6, 2017

Congressional requesters:

In 2015, the Medicaid program financed coverage for an estimated 68.9 million low-income and medically needy individuals—nearly one-quarter of the U.S. population—and is the largest source of funding of health care for America’s most vulnerable populations.<sup>1</sup> In recent years, the federal-state program has undergone steady growth, particularly since the enactment in 2010 of the Patient Protection and Affordable Care Act (PPACA), under which states have the option to expand program eligibility to certain nonelderly individuals.<sup>2</sup> A significant pressure on federal and state budgets, Medicaid’s estimated outlays for fiscal year 2015 were \$554.3 billion, of which \$347.5 billion was financed by the federal government and \$206.8 billion by the states.<sup>3</sup>

Within broad federal parameters, Medicaid allows states significant flexibility to design and implement their programs, resulting in more than 50 distinct state-based programs.<sup>4</sup> This flexibility has allowed states to fashion their programs based on their unique needs; however, it has also complicated oversight. The states are responsible for day-to-day operations of their Medicaid programs, while the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicaid, has a critical role

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<sup>1</sup>Department of Health & Human Services, Office of the Actuary, Centers for Medicare & Medicaid Services, *2015 Actuarial Report on the Financial Outlook for Medicaid*.

<sup>2</sup>Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA.

Historically, Medicaid eligibility has been limited to certain categories of low-income individuals—such as children, parents, pregnant women, persons with disabilities, and individuals age 65 and older. However, PPACA permitted states to expand their Medicaid programs by covering low-income adults not historically eligible for Medicaid coverage. As of July 2016, 31 states and the District of Columbia have opted to expand their Medicaid programs. The State Children’s Health Insurance Program (CHIP) is a joint federal-state program for children whose household incomes are too high for Medicaid eligibility.

<sup>3</sup>See Office of the Actuary, *2015 Actuarial Report*.

<sup>4</sup>For the purposes of this report, we include the District of Columbia as a state.

in overseeing states' compliance with federal requirements, including ensuring that federal Medicaid payments are made appropriately.

CMS oversight relies in great part on state-reported data on multiple aspects of the Medicaid program, including expenditures and service utilization.<sup>5</sup> However, we and others have identified the lack of accurate, complete, and timely data at the federal level needed to oversee the diverse and complex state Medicaid programs.<sup>6</sup> These concerns are not new—and we have designated Medicaid as a high-risk program since 2003 due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight. Recent trends in improper payments, however, have exacerbated concerns about Medicaid oversight.<sup>7</sup> In particular, improper payments in fiscal year 2016 were estimated to be \$36.3 billion of Medicaid's expenditures, a significant increase from the estimated \$14.4 billion in improper payments in fiscal year 2013.<sup>8</sup> Recognizing the need for improved Medicaid data, CMS has undertaken a number of steps aimed at streamlining and improving the quality of data currently reported by states and available to CMS for oversight purposes.

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<sup>5</sup>CMS relies on these and other data, such as data on enrollment, providers, and nursing home quality, to inform its oversight of the Medicaid program. For this report, we focused on expenditure and utilization data, because they are critical to determining whether Medicaid payments are appropriate and access to care is sufficient.

<sup>6</sup>For example, in a report summarizing concerns facing the Medicaid program, we stressed the importance of quality data in increasing transparency and improving oversight. See GAO, *Medicaid: Key Issues Facing the Program*, [GAO-15-677](#) (Washington, D.C.: July 30, 2015). The HHS Office of Inspector General (HHS-OIG) also identified improving the effectiveness of Medicaid data and systems as a key performance and management challenge. See *OIG's FY 2015 Top Management and Performance Challenges Facing the Department of Health and Human Services*, <https://oig.hhs.gov/reports-and-publications/top-challenges/2015/challenge01.asp>, accessed November 10, 2016. The Medicaid and CHIP Payment and Access Commission (MACPAC) also noted areas where better federal data on Medicaid are needed for improved understanding for policy analysis, such as service use among enrollees in managed care. See *MACPAC Report to the Congress on Medicaid and CHIP*, Chapter 6, "Improving Medicaid and CHIP Data for Policy Analysis and Program Accountability," (March 2011).

<sup>7</sup>An improper payment is defined as 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, or any payment for a good or service not received.

<sup>8</sup>See Department of Health and Human Services, *FY 2016 Agency Financial Report* (Washington, D.C.: Nov. 14, 2016).

You asked us to examine the usefulness of available Medicaid data for program oversight purposes, and CMS's efforts to address known data limitations. In this report, we

1. describe how available Medicaid expenditure and utilization data affect CMS's ability to oversee the Medicaid program; and
2. examine the extent to which CMS has undertaken efforts to improve the data available to oversee states' Medicaid programs.

To describe how the available Medicaid expenditure and utilization data affect CMS's ability to oversee the Medicaid program, we reviewed relevant federal laws, regulations, and federal internal control standards.<sup>9</sup> We also reviewed our own reports that specifically examined Medicaid expenditure and utilization data that were issued between March 2010, when PPACA was signed into law, and September 2016, the most recently available when we conducted this review. A list of the related GAO reports and testimonies we reviewed is included at the end of this report. For the same time period, we also reviewed reports on Medicaid expenditure and utilization data published by other entities, including the Medicaid and CHIP Payment and Access Commission (MACPAC), the Congressional Research Service (CRS), and HHS's Office of Inspector General (HHS-OIG).<sup>10</sup> We interviewed CMS officials to verify that these reports' findings on Medicaid expenditure and utilization data were current.

To examine the extent to which CMS has taken steps to improve the data available to oversee states' Medicaid programs, we reviewed federal laws, regulations, and guidance, and CMS's formal responses to GAO recommendations regarding identified data limitations. We also interviewed CMS officials about current or future initiatives to address data quality and the status of those initiatives, and reviewed relevant agency documentation.

We conducted this performance audit from February 2016 to January 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to

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<sup>9</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

<sup>10</sup>CHIP stands for State Children's Health Insurance Program.

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obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Medicaid, by design, allows significant flexibility for states to design and implement their programs. Within broad federal guidelines and under federally approved plans, states have some discretion in setting Medicaid eligibility standards and provider payment rates; determining the amount, scope, and duration of covered benefits, and how these benefits are delivered; and developing their own administrative structures. For example, states may pay health care providers for each service they provide on a fee-for-service (FFS) basis; contract with managed care organizations (MCO) to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary per month; or rely on a combination of both delivery systems.<sup>11</sup> This flexibility has influenced the development of the program and has resulted in over 50 distinct state-based programs that vary in how health care is delivered, financed, reimbursed, and overseen.

Medicaid expenditures are financed by both the federal government and the states. The rate at which the federal government matches most state expenditures—the Federal Medical Assistance Percentage (FMAP)—also varies by state and by beneficiary eligibility type, which also contributes to program variation. Specifically, the federal government pays a higher portion of Medicaid expenditures in states with low per capita incomes relative to the national average, and pays different portions for expenditures for beneficiaries qualifying for Medicaid under traditional eligibility rules and those qualifying under a PPACA expansion.<sup>12</sup> The resulting variation complicates program oversight efforts, which are

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<sup>11</sup>States vary considerably in the extent to which they enroll beneficiaries in managed care; however, in 2014, over three-quarters of Medicaid enrollees nationwide—55.2 million individuals—were enrolled in managed care. See *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, Centers for Medicare & Medicaid Services and Mathematica Policy Research, (Spring 2016).

<sup>12</sup>For a discussion of these different eligibility groups, see GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, [GAO-16-53](#) (Washington, D.C.: Oct. 16, 2015).



shared by the federal government and the states, and are aimed, in part, at ensuring that funds are used appropriately and that enrollees have access to covered benefits. (See table 1.)

**Table 1: Examples of State Flexibility in Medicaid Program Design and Oversight**

Program flexibility	Description	Oversight example <sup>a</sup>
Eligibility	<p>States determine program eligibility:</p> <ul style="list-style-type: none"> <li>States are required to cover certain categories of low-income individuals, such as pregnant women, parents and children, and individuals who are aged or disabled.</li> <li>Under the Patient Protection and Affordable Care Act (PPACA), states can opt to expand Medicaid to cover certain childless adults with incomes at or below 133 percent of the federal poverty level.<sup>b</sup></li> </ul>	<p>The applicable Federal Medical Assistance Percentage must be applied to each eligibility group to ensure appropriate federal payment, and to protect the program from improper payments.</p>
Services	<p>Subject to federal requirements, states determine the amount, scope, and duration of services covered in their Medicaid programs.</p> <ul style="list-style-type: none"> <li>States must cover a wide array of mandatory services, which include inpatient hospital services, physician services, and nursing facility services.</li> <li>States may cover additional services.</li> </ul>	<p>Beneficiaries' utilization of services must be reported.</p>
Payments	<p>States enroll providers and establish payment rates.</p> <ul style="list-style-type: none"> <li>States may reimburse providers based on claims submitted for each covered service delivered to a beneficiary, referred to as a fee-for-service payment.</li> <li>States may pay managed care organizations (MCO) based on a predetermined, per beneficiary, per month basis.</li> <li>States make supplemental payments to providers, which are above the regular amounts paid for a service, and may or may not be based on claims for specific services. Such payments include, for example                             <ul style="list-style-type: none"> <li>Disproportionate share hospital (DSH) payments.<sup>c</sup></li> <li>Medicaid upper payment limit (UPL) payments.<sup>d</sup></li> </ul> </li> </ul>	<p>Payments to providers must be economical, efficient, and for Medicaid purposes.</p> <p>Payments to providers must be sufficient so that Medicaid care and services are available at least to the extent that such care and services are available to the general population in the geographic area.</p> <p>Payments to MCOs must be actuarially sound.</p> <p>States and CMS are required to ensure appropriate payments, and to protect Medicaid from fraud, waste, and abuse.</p>
Sources of state financing	<p>States can rely on various sources to finance the state share of their Medicaid costs, including</p> <ul style="list-style-type: none"> <li>state general funds,</li> <li>health care provider taxes and donations, and</li> <li>fund transfers from local government entities.<sup>e</sup></li> </ul>	<p>At least 40 percent of the state share must be from state funds, which include state general funds, provider taxes, and transfers from other state agencies. The remaining 60 percent may be derived from fund transfers from local government entities.</p>

Source: GAO analysis of Medicaid requirements. | GAO-17-173

<sup>a</sup>The states have primary responsibility for program integrity, because they enroll providers, establish payment policies, process claims, and pay for services furnished to beneficiaries. CMS is responsible for overseeing states' design and operation of their Medicaid programs, and ensuring that federal funds are appropriately spent.

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<sup>b</sup>PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)(I).

<sup>c</sup>States are required to make DSH payments to hospitals that serve large numbers of Medicaid and uninsured, low-income individuals to help offset these hospitals' uncompensated care costs of serving such individuals. See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

<sup>d</sup>Under federal law, to receive federal matching funds, payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy, efficiency, and quality of care; and (3) must not exceed the Medicaid upper payment limit (UPL). See 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. §§ 447.272, 447.321 (2015). The UPL is based on what Medicare would pay for comparable services. Based on the gap between the UPL and regular Medicaid payments, states can make supplemental payments to selected providers. UPL supplemental payments represent a significant component of Medicaid spending, totaling over \$22 billion in fiscal year 2014.

<sup>e</sup>Local government entities include counties, cities, and hospitals or other providers that are owned or operated by local governments.

To help inform its oversight, CMS relies on data that states submit from their respective Medicaid Management Information Systems (MMIS). MMIS are claims processing and information retrieval systems that support the administration of the program, which states are required to implement in order to receive federal matching funds.<sup>13</sup> Two data sets derived from state MMIS provide CMS with state data on program expenditures and utilization.<sup>14</sup>

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<sup>13</sup>See 42 U.S.C. § 1396b(r). States receive a 90 percent federal match for the costs associated with the development of their MMIS system and a 75 percent match for the costs associated with ongoing MMIS maintenance and operation. See 42 U.S.C. §§ 1396b(a)(3)(A)(i), (B).

<sup>14</sup>CMS relies on other state-reported data to oversee Medicaid expenditures and utilization. CMS uses these data to assess the effectiveness of state programs for children and to estimate improper payments through the Payment Error Rate Measurement (PERM) program. For example, states must report the number of children receiving well-child checkups, and the number of children referred for treatment and services for conditions identified during well-child checkups under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit on the CMS-416. Through the PERM, CMS measures and reports to Congress improper payment rates in three component areas: (1) fee-for-service claims, (2) managed care, and (3) eligibility. In light of changes to Medicaid eligibility standards and state eligibility systems necessitated by PPACA, CMS has suspended the eligibility portion of the PERM program until fiscal year 2018.

- The CMS-64 contains service expenditures and administrative expenses that are not linked to individual enrollees.<sup>15</sup> State Medicaid agencies must submit this information each quarter 30 days after a quarter has ended. CMS-64 data are reported at a state aggregate level, such as a state's total expenditures for such categories as inpatient hospital services and prescription drugs, and are the basis for determining federal reimbursements to states for Medicaid expenditures. The CMS-64 also includes expenditures for supplemental payments, including disproportionate share hospital (DSH) payments.<sup>16</sup>
- The Medicaid Statistical Information System (MSIS) is an eligibility and claims data set, and is the federal source of state Medicaid expenditure and utilization data that can be linked to a specific enrollee. For each Medicaid beneficiary, MSIS provides data on eligibility status, service utilization, and expenditures, and CMS uses these data for policy analysis and forecasting expenditures.<sup>17</sup> State Medicaid agencies are required to provide CMS, through MSIS, quarterly electronic files approximately 45 days after a quarter has ended. These files contain (1) information on persons covered by Medicaid, known as "eligible files"; and (2) adjudicated claims, known as the "paid claims file," for medical services reimbursed by the Medicaid program.<sup>18</sup>

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<sup>15</sup>For purposes of this report, we refer to form CMS-64 as "CMS-64." The CMS-64 is titled the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The information is stored in the Medicaid Budget and Expenditure System. States are required to submit aggregate total quarterly Medicaid expenditures on the form CMS-64 no later than 30 days after the end of each quarter. 42 C.F.R. § 430.30 (2015). CMS reconciles the amount of federal funds advanced to the state at the beginning of the quarter with the amount of federal funds claimed for payments made during the quarter to finalize the federal funding provided to the state. This results in a reconciliation adjustment to finalize the federal reimbursement to the state for the quarter.

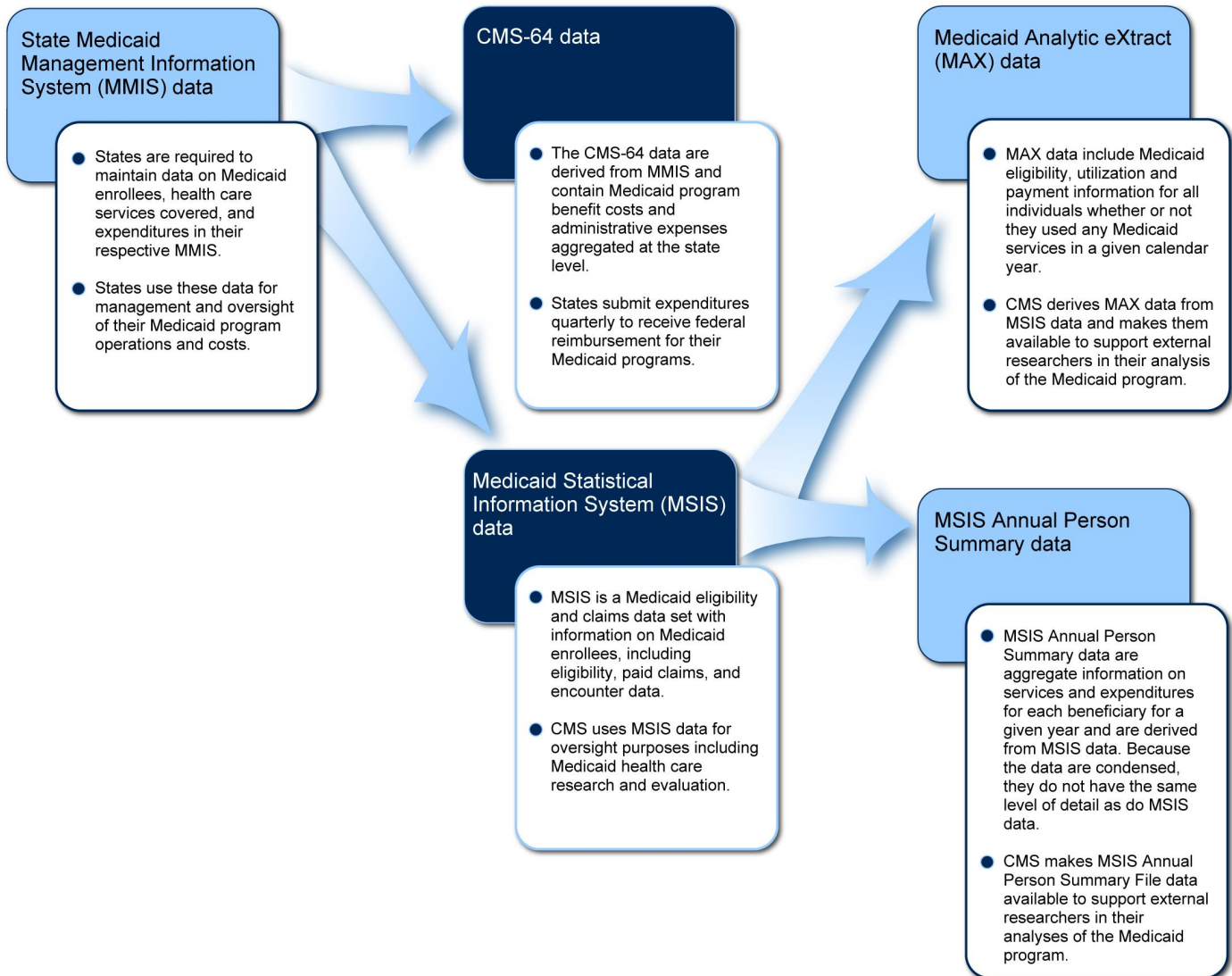
<sup>16</sup>DSH payments are required to be made to hospitals that serve a disproportionate share of low-income and Medicaid patients to help offset hospitals' uncompensated costs of serving these individuals. See 42 U.S.C. §§ 1396a(a)(13)(A)(iv), 1396r-4.

<sup>17</sup>These data also include the utilization of services provided through MCOs, also known as managed care encounter data. We previously found that MSIS data are not used by the states to manage the daily operations of their Medicaid programs. See GAO, *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, [GAO-13-47](#) (Washington, D.C.: Oct. 29, 2012.)

<sup>18</sup>Each state's eligible file contains one record for each person covered by Medicaid for at least 1 day during the reporting quarter. Individual eligible files consist of demographic and monthly enrollment data. Paid claims files contain information on medical service-related claims and MCO payments.

To support external researchers' analyses of the Medicaid program, CMS also makes excerpts of MSIS data available through the Medicaid Analytic eExtract (MAX), which includes data on Medicaid enrollment, service use, and expenditures, and the MSIS Annual Person Summary file, which includes aggregated expenditure and utilization data for each beneficiary. (See fig. 1.)

**Figure 1: Key Medicaid Data Sets on Expenditures and Utilization**



Source: GAO analysis of information from CMS. | GAO-17-173

Note: CMS-64 data also include expenditures derived from non-MMIS sources.

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## CMS's Oversight Is Hindered by Insufficient Expenditure and Utilization Data

Based on our review of reports issued by GAO and other entities, we determined that available Medicaid expenditure and utilization data do not provide CMS with sufficient information to consistently ensure that payments are proper or that beneficiaries have access to covered services, which is inconsistent with federal internal control standards that state that management should use quality information to achieve the entity's objectives.<sup>19</sup> CMS should rely on quality information to oversee the Medicaid program.

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### Expenditure Data

The CMS-64, which serves as the basis of calculating the amount of federal matching funds for states, and MSIS, which is designed to report individual beneficiary claims data, have the potential to offer a robust view of payments and overall spending in the Medicaid program. However, as the following examples from our work on supplemental payments, states' sources of financing, and beneficiary eligibility under PPACA demonstrate, the usefulness of the CMS-64 and MSIS data is limited, because of issues with completeness, accuracy, and timeliness.<sup>20</sup> For example, neither the CMS-64 nor the MSIS is designed to capture detailed information on payments made to individual providers or the non-state sources of the state share of Medicaid payments. Without more transparent information on program payments and state funding sources, CMS is unable to determine the appropriateness of program expenditures and ensure the fiscal integrity of the program.<sup>21</sup>

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<sup>19</sup>See [GAO-14-704G](#).

<sup>20</sup>See [GAO-13-47](#).

<sup>21</sup>Prior work also identified the lack of provider-specific data as affecting CMS's ability to conduct effective program integrity activities. See GAO, *National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States*, [GAO-12-627](#) (Washington D.C.: June 14, 2012). Since this report was issued, CMS has implemented our recommendation and shifted its audit strategy to collaborate more with states and use their MMIS data, which are more current and complete than MSIS data.

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## Supplemental payments

States report aggregate data regarding supplemental payments on the CMS-64, but neither the CMS-64 nor MSIS identifies supplemental payments made to individual providers.<sup>22</sup> As a result, we had to rely on alternative sources to determine Upper Payment Limit (UPL) supplemental payment amounts in conducting two reviews.<sup>23</sup> In particular, we examined states' mandatory DSH reports, which include some information on UPL supplemental payments made to DSH hospitals, and interviewed providers from selected states to identify their uses of these payments.<sup>24</sup> Based on these efforts, we made the following observations, among others.

- Thirty-nine states made UPL supplemental payments to 505 hospitals that, along with their regular Medicaid payments, exceeded those

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<sup>22</sup>Supplemental payments are payments that states make to providers that are above the regular amounts paid for a service and may or may not be based on claims for specific services. CMS officials acknowledged that the CMS-64 does not specifically identify supplemental payments made to individual providers, but noted that it may request detailed support at the provider level from the state at any time during the quarterly CMS-64 reviews. These officials did not offer information on the extent to which CMS requests these data from states, if at all.

<sup>23</sup>See GAO, *Medicaid: More Transparency and Accountability for Supplemental Payments are Needed*, [GAO-13-48](#), (Washington, D.C.: Nov. 26, 2012); and *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, [GAO-16-108](#), (Washington, D.C.: Feb. 5, 2016).

Under federal law, to receive federal matching funds, payments must not exceed the Medicaid UPL. See 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. §§ 447.272, 447.321 (2015). The UPL is based on what Medicare would pay for comparable services. Based on the gap between the UPL and regular Medicaid payments, states can make supplemental payments to selected providers. States are also required to make DSH supplemental payments to hospitals that serve large numbers of Medicaid and uninsured, low-income individuals to help offset these hospitals' uncompensated care costs of serving such individuals.

<sup>24</sup>DSH reports are independently audited reports that states are required to submit to CMS annually identifying each hospital that received a DSH payment in the preceding fiscal year and the amount of the payment, as well as additional information the agency requires to ensure the appropriateness of the payment. See 42 U.S.C. §1396r-4(j).

Under Medicaid rules, states can obtain federal matching funds for payments made under the UPL, which is based on the amount Medicare would pay for comparable services as applied to all providers within specified ownership classes. Medicaid UPL supplemental payments, which are above the regular Medicaid payments, but within the UPL, are not limited to an individual provider's cost of providing Medicaid services.

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hospitals' total costs of providing Medicaid-funded care by \$2.7 billion.<sup>25</sup>

- Certain hospitals use these payments for a wide range of purposes, from covering the costs of uninsured patients to funding general hospital operations, maintenance, and capital purchases, such as a helicopter.<sup>26</sup>

These findings suggest that further examination of UPL supplemental payments is warranted; however, data on these payments are incomplete as states are not required to report such payments to non-DSH hospitals or to other providers at the provider level. By not collecting complete or consistent data about these payments to all providers—either through the CMS-64 or another vehicle—CMS is missing an opportunity to ensure that such payments were made for Medicaid purposes and were consistent with Medicaid payment principles.<sup>27</sup>

### **States' sources of financing**

States have increasingly relied on health care providers and other non-state sources to fund the state share of Medicaid payments. However, CMS does not collect accurate and complete data on state sources of funds to finance the Medicaid program, thus complicating CMS's ability to fully assess whether state financing of the nonfederal share complies with federal law, or the extent to which the increased reliance on providers and local governments serves to provide fiscal relief to states and shifts costs to the federal government.

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<sup>25</sup>Of the 505 hospitals, 310 received a supplemental payment that, when added to the regular Medicaid payments the hospital received, resulted in total Medicaid payments exceeding Medicaid costs by about \$1.9 billion. The remaining 195 hospitals received regular Medicaid payments that exceeded Medicaid costs before they received a supplemental payment, and total payments exceeded costs by about \$900 million. See [GAO-13-48](#).

<sup>26</sup>See [GAO-16-108](#).

<sup>27</sup>For example, with information on UPL supplemental payments from all hospitals, CMS could determine the extent to which these payments are targeted to a small number of providers, are related to those providers' Medicaid workload, and resulted in total Medicaid payments that exceeded an individual provider's costs of providing Medicaid services.

- We and MACPAC found that CMS does not have complete data on the sources or amounts of local government funds states use to finance their nonfederal share.<sup>28</sup>
- We and CRS also determined that the CMS-64 contained incomplete data on provider taxes, and we noted that CMS has not assessed the accuracy and completeness of those data.<sup>29</sup> For a 2014 report, we asked states to identify and quantify the sources of their nonfederal share, and 47 states indicated that they had at least one provider tax or donation in effect in 2012. In comparing these responses to the provider tax and donation data they reported on the CMS-64 for the same year, we found that 6 states did not report one or more provider taxes.

### **Beneficiary eligibility under PPACA**

As of October 2016, over 30 states have opted to expand their Medicaid program under PPACA. Because the FMAP rate can vary by beneficiary eligibility type, it is critical that CMS apply the correct matching rate for each respective eligibility group in these states to ensure proper payment amounts. However, CMS does not collect accurate state data on Medicaid enrollment by eligibility type in the CMS-64, thus complicating its ability to identify erroneous expenditures due to incorrect eligibility determinations. For example

- We reviewed state eligibility reviews and noted that, in 8 of the 9 states reviewed, the state identified errors that resulted in incorrect eligibility determinations, including enrollment of individuals with

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<sup>28</sup>See GAO, *Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods*, [GAO-16-195T](#) (Washington, D.C.: Nov. 3, 2015); *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, [GAO-14-627](#) (Washington, D.C.: July 29, 2014); and *Medicaid: Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight*, [GAO-14-817T](#) (Washington, D.C.: July 29, 2014). Also see MACPAC, *Report to the Congress on Medicaid and CHIP* (March 2016).

<sup>29</sup>States may, subject to certain requirements, receive funds to finance Medicaid payments from health care providers, through provider taxes—taxes levied on providers such as hospitals or nursing facilities. Under federal law, provider taxes must be broad-based, must be uniformly imposed, and must not hold providers harmless; that is, they must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back. See [GAO-16-195T](#); [GAO-14-627](#); and CRS, *Medicaid Provider Taxes*, 7-5700 (Washington, D.C.: March 15, 2012).



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incomes exceeding Medicaid standards—totaling up to \$48,000 in improper payments identified in one state alone.<sup>30</sup>

- At the time of our review, CMS had not reviewed federal Medicaid eligibility determinations in the 10 states that had delegated authority to the federal government to make these determinations, thus creating a substantial gap in its oversight of Medicaid eligibility determinations.

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## Utilization Data

MSIS is the primary data source available to CMS on beneficiaries' utilization of services as it includes claims data submitted by FFS providers and encounter data submitted by MCOs.<sup>31</sup> However, we and HHS-OIG have identified incomplete and untimely state MSIS data, particularly managed care encounter data. Without better MSIS data, CMS may not be able to identify billing patterns that indicate inappropriate provider billing or ensure that beneficiaries have access to covered services.

- In July 2015, HHS-OIG reviewed states' compliance with federal requirements regarding the submission of Medicaid encounter data and determined that 11 states did not report encounter data for all managed care plans operating in their states as required.<sup>32</sup> In that

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<sup>30</sup>See [GAO-16-53](#).

<sup>31</sup>Encounter data refer to data on the utilization of services provided through Medicaid MCOs.

CMS also relies on other state data, such as the CMS-416 (the EPSDT Participation Report) to oversee beneficiaries' utilization. In reviewing all states' CMS-416 reports, we found that 10 states made reporting errors large enough to result in an overstatement of the extent to which children received EPSDT services and that states did not always report required data on the number of children referred for additional services. Even in states that included referral information, states did not identify whether those children actually received the services. See GAO, *Medicaid and CHIP: Reports for Monitoring Children's Care Services Need Improvement*, [GAO-11-293R](#) (Washington, D.C.: April 5, 2011). While CMS has taken steps to address reporting errors on the CMS-416, it has no plans to require states to submit data on whether children received the treatment services for which they were referred.

<sup>32</sup>See HHS-OIG, *Not All States Reported Medicaid Managed Care Encounter Data as Required*, OEI-07-13-00120 (Washington, D.C.: July 2015). This report was an update to a 2009 review, which found that 15 states did not report any encounter data to MSIS. For all claims filed on or after January 1, 1999, states have been required to electronically transmit claims data, including detailed individual enrollee encounter data in a format consistent with MSIS. See 42 U.S.C § 1396b(r)(1)(F).

same year, we could not assess utilization patterns for Medicaid managed care beneficiaries in 32 states, because MSIS data were either not available or were unreliable.<sup>33</sup> The lack of complete and reliable encounter data presents a significant oversight challenge for CMS given that over three-quarters of Medicaid beneficiaries were enrolled in managed care in 2014.

- We and HHS-OIG found evidence of states not reporting MSIS data on time. For example, in an October 2012 report examining consistencies between CMS-64 and MSIS data, we found that 37 states were late reporting their quarterly MSIS data by six quarters in July 2012.<sup>34</sup> Although CMS requires states to submit MSIS data within 45 days of the end of a fiscal quarter, we found that states' reporting of MSIS data and the subsequent validation process are up to 3 years late.<sup>35</sup> Similarly, the July 2015 HHS-OIG report noted above, also identified 8 of the 38 states it reviewed as not reporting any MSIS encounter data by the required deadline.<sup>36</sup>
- In a 2015 review of Medicaid prescription-drug fraud controls, we also identified how inaccurate and incomplete encounter data can affect state program integrity efforts. Data from 4 of the 11 states we reviewed had missing or unreliable provider information or encounter data, thus affecting those states' ability to identify incidents of fraud, waste, or abuse.<sup>37</sup>

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## CMS Has a Key Initiative to Improve Medicaid Data, but Uncertainty Exists Regarding its

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<sup>33</sup>Among other reasons, we determined that data were unreliable in states that reported that fewer than 30 percent of beneficiaries used at least one service, a threshold established by Mathematica for evaluating the completeness and usability of the data, and states that did not report services using a standard coding convention. See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, [GAO-15-481](#) (Washington, D.C.: May 29, 2015).

<sup>34</sup>See [GAO-13-47](#).

<sup>35</sup>According to CMS officials, states that delay reporting can have issues with both the timeliness and quality of their submissions. If states submit poor quality data, CMS may reject the submission, resulting in further delays.

<sup>36</sup>HHS-OIG, OEI-07-13-00120.

<sup>37</sup>GAO, *Medicaid: Additional Reporting May Help CMS Oversee Prescription-Drug Fraud Controls*, [GAO-15-390](#) (Washington, D.C.: July 8, 2015).

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## Implementation and Effect on Program Oversight

CMS officials identified the Transformed Medicaid Statistical Information System (T-MSIS) initiative as the agency's primary effort to improve Medicaid expenditure and utilization data, and highlighted aspects of the initiative intended to improve their accuracy, completeness, and timeliness. However, less than half of the states are submitting T-MSIS data files to CMS, and it is uncertain when the remaining states will submit these data or how CMS will ensure their quality or use them for oversight purposes.

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### CMS Officials Cite T-MSIS as the Key Effort among Several to Improve Medicaid Data and Program Oversight

CMS has acknowledged the need for improved Medicaid data, and has undertaken a number of steps aimed at streamlining and improving the quality of data currently reported by states and available to CMS for oversight purposes.<sup>38</sup> For example, since 2011, CMS has been working to implement the T-MSIS initiative to increase and improve the data collected through MSIS. T-MSIS is to include data about enrollees, services, and costs, including FFS claims, managed care encounters, beneficiary eligibility and demographics, and provider enrollment.<sup>39</sup> According to CMS officials, T-MSIS includes aspects designed to improve the completeness, accuracy, and timeliness of available state data, as well as their utility for states.<sup>40</sup>

- **Completeness:** T-MSIS is designed to capture significantly more data from states than is the case with MSIS. CMS requires states to report

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<sup>38</sup>In its Comprehensive Medicaid Integrity Plan, CMS noted efforts to improve the quality and consistency of Medicaid data reported to CMS. See CMS, *Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018*.

<sup>39</sup>T-MSIS is a continuation of CMS's efforts to improve MSIS data. CMS conducted pilot projects (MSIS Plus in 2009 and MSIS Redesign in 2011) to provide more complete, accurate, and timely national data, and to limit separate data requests to states.

<sup>40</sup>CMS officials noted that the T-MSIS data initiative is part of a broader agency-wide initiative—the Medicaid and CHIP Business Information Solutions—that began in 2010 to improve Medicaid and CHIP data infrastructure and technology. Other components of this initiative include MACPro, which accepts and stores requests for state plan amendments, waivers, and other documents.

data on approximately 550 variables across eight data files in T-MSIS, a significant contrast to the approximately 200 variables required in MSIS.

- T-MSIS requires states to report three additional data files, including specific files on providers, third-party liability, and MCOs, thus collecting data not previously reported that could provide CMS information to enhance its oversight efforts.<sup>41</sup>
  - The provider file includes a unique identifier for each provider, as well as data fields to show provider specialty and practice locations. Each of these has the capacity to assist CMS oversight in terms of providing insight on provider referrals, Medicaid payments to specific providers, and identifying ineligible providers.
  - The third party liability file includes data on whether a beneficiary has any health insurance in addition to Medicaid, which would provide CMS with data on potentially liable third parties.<sup>42</sup>
  - The managed care file includes more detailed information on MCOs, such as type and name of managed care plans, covered eligibility groups, service areas, and reimbursement arrangements. In addition to identifying failure to report encounter data, this file could help CMS's oversight by allowing the agency to identify excess plan profit and volatility of expenditures for some enrollee groups across states.
- In addition to the data variables associated with the three new files, CMS expanded the scope of data to be collected through the existing MSIS files. For example, according to CMS officials, T-MSIS is to collect more detailed information on enrollees, including their citizenship, immigration, and disability status, as well as expanded diagnosis and procedure codes associated with their treatments.
- Accuracy: Within T-MSIS, there exist aspects aimed at improving the accuracy of data initially submitted by states. For example, T-MSIS

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<sup>41</sup>Five data files are collected through MSIS: an eligibility file and four claims files (inpatient, long-term care, pharmacy, and other).

<sup>42</sup>See GAO, *Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts*, [GAO-15-208](#) (Washington, D.C.: Jan. 28, 2015).

includes approximately 3,500 automated quality checks, which provide states with feedback on data format and consistency, in contrast to MSIS, which has relatively few automated checks. T-MSIS quality checks include ensuring that a beneficiary's date of birth is a valid date and that a beneficiary's age is under a reasonable limit. Other quality checks are to ensure logical relationships across T-MSIS files, such as ensuring that the beginning date of service on claims are on or after a beneficiary's date of birth. According to agency officials, CMS accepts state data for subsequent processing, provided the data are correctly formatted. According to CMS officials, states have access to error reports that are generated as a result of processing their T-MSIS data.

- **Timeliness:** CMS requires states to report T-MSIS data to CMS monthly, versus quarterly, as is the case with MSIS data.
- **Utility for states:** T-MSIS includes aspects aimed at improving state oversight and reducing state burden. For example, while states have not relied on MSIS data to oversee their Medicaid programs, T-MSIS is intended to eventually provide states with the capability to analyze and compare their program data to other states, potentially enhancing their ability to manage expenditures and identify concerns regarding access to care. According to CMS officials, the agency also intends to access certain state data directly through T-MSIS, rather than separately requesting such data from the states, thereby reducing the number of data requests that CMS makes to states.<sup>43</sup>

In addition to its ongoing implementation of T-MSIS, CMS has taken other actions—for example, issuing regulations and guidance—to improve data reporting and enhance available data; however, given the recent nature or future implementation dates of these actions, their effect on CMS's ability to oversee the Medicaid program is not fully known.

- The May 2016 managed care rule includes provisions intended to strengthen data the agency collects on managed care utilization and relevant for program integrity, which could help improve MCO oversight, the need for which was identified in several GAO reports.<sup>44</sup> For example, the rule requires states to include provisions regarding

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<sup>43</sup>For example, CMS plans to use T-MSIS to obtain data on children referred to services under the EPSDT benefit, thus eliminating the need for states to submit the CMS 416 reports. Similarly, CMS would no longer need to separately obtain data from the states for certain aspects of program integrity activities, such as calculating states' PERM rates.

<sup>44</sup>81 Fed. Reg. 27498 (May 6, 2016).

the maintenance of encounter data in contracts with MCOs and limited benefit plans, to have procedures in place to ensure that enrollee encounter data these entities submit are complete and accurate, and includes financial consequences for lack of compliance.<sup>45</sup> Although MCOs have been expressly required to report encounter data under statute since 2010, CMS's May 2016 rule provides more clarity regarding the format and collection of these data. However, because these rules will not take effect until 2017 and 2018, their success in improving data is dependent on state and CMS implementation.<sup>46</sup> In addition, the managed care rule increases and clarifies state responsibilities related to overseeing payments to and by MCOs, which addresses a GAO recommendation that CMS hold states accountable for managed care program integrity by requiring them to conduct audits of MCOs.<sup>47</sup> In particular, the managed care rule requires that states, at least once every 3 years, audit encounter and financial data submitted by MCOs.<sup>48</sup>

- A December 2015 final rule includes more targeted financial consequences for states that do not comply with data submission requirements, including T-MSIS.<sup>49</sup> While CMS previously had the authority to reduce federal financial participation for system operations from 75 percent to 50 percent if any system failed to meet any or all

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<sup>45</sup>Limited benefit plans are paid on a per person basis to provide a defined set of services. Under the rule, CMS will assess the state's submission of these entities' enrollee encounter data. If, after being notified of compliance issues, the state is unable to submit compliant data, CMS will take appropriate steps to defer or disallow federal financial participation on all or part of an MCO's contract based on the enrollee and specific service type of the non-compliant data. 81 Fed. Reg. at 27881, 27895 (to be codified at 42 C.F.R. § 438.242, 438.818).

<sup>46</sup>The provisions for maintaining encounter data and ensuring encounter data accuracy apply to contracts beginning in July 2017. The provision for financial consequences for lack of compliance with data submission requirements applies to contracts beginning in July 2018.

<sup>47</sup>For example, states must require MCOs and limited benefit plans to implement procedures to detect and prevent fraud, waste, and abuse. Further, they must have procedures for prompt reporting to the state of all overpayments identified or recovered, specifying those due to potential fraud. See 81 Fed. Reg. at 27891 (to be codified at 42 C.F.R. § 438.608).

See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, [GAO-14-341](#) (Washington, D.C.: May 19, 2014).

<sup>48</sup>See 81 Fed. Reg. at 27890 (to be codified at 42 C.F.R. § 438.602(e)).

<sup>49</sup>See 80 Fed. Reg. 75817, 75834, 75843 (Dec. 4, 2015) (to be codified at 42 C.F.R. § 433.120).

requirements, the final rule provides CMS with the option to tailor the federal matching rate reduction to the specific operational expenditures related to the system component that does not meet applicable requirements. Having the ability to impose more targeted funding reductions may enable CMS to more effectively leverage improved state compliance with reporting requirements.

- In December 2015, in response to a GAO recommendation to routinely monitor and share information regarding key third-party liability efforts and challenges across states, CMS provided states with an updated guide on Medicaid third-party liability practices with information to help make states more aware of such efforts and challenges. This updated guide is an important tool that could help states ensure that Medicaid pays only after other liable third parties.<sup>50</sup>
- In its Comprehensive Medicaid Integrity Plan for fiscal years 2014-2018, CMS noted that it is leveraging available Medicare data to assist states in identifying providers who are enrolled in both Medicare and Medicaid, and may be involved in fraudulent or abusive billing practices. CMS officials also reported they adjusted the CMS-64 to improve states' reporting of eligibility categories and UPL supplemental payments and trained states on how to report UPL supplemental payments.

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## Uncertainty Surrounds States' T-MSIS Implementation and CMS's Plans for These Data in Enhancing Program Oversight

Although T-MSIS may ultimately provide CMS with improved data to enhance its oversight of the Medicaid program, it is unclear when T-MSIS data will be available from all states. Federal internal control standards require agency management to complete actions to improve deficiencies on a timely basis; however, T-MSIS implementation, which began in

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<sup>50</sup>Centers for Medicare & Medicaid Services, "Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Program: A Guide to Effective and Innovative State Agency Practices. Update Issued December 2015"; and [GAO-15-208](#).

Federal law requires state Medicaid programs to identify and seek payment from liable third parties before billing Medicaid. In contrast, Medicaid MCOs are typically responsible for third-party liability administration and activities, and states are responsible for overseeing these activities. However, neither the updated guide nor the May 2016 final Medicaid managed care rule provides guidance to states on their oversight of third-party liability efforts conducted by Medicaid MCOs.

March 2011 as a pilot program in 12 states, has been delayed for several years. The original date for nationwide submission was July 2014; as of October 2016, 18 states were submitting T-MSIS data, and CMS officials were uncertain as to when the remaining 33 states would begin submitting these data.<sup>51</sup> Agency officials stated that for a state to be considered submitting T-MSIS data, it must submit all eight data files, but not necessarily all data variables within each file. CMS officials currently estimate that states representing over 70 percent of the Medicaid population will be submitting T-MSIS data by the end of calendar year 2016.

To expedite states' implementation of T-MSIS, CMS officials noted that they are focusing their efforts on the states they have determined are closest to implementing T-MSIS. According to these officials, CMS has had calls with these states to inquire about their plans, including what help the state may need from the agency. CMS has categorized the remaining states according to their readiness to begin submitting T-MSIS data.

CMS and state officials identified several factors contributing to states' delayed T-MSIS implementation. For example, in addition to requiring states to submit significantly more information than they have in the past, T-MSIS implementation also coincides with the ongoing efforts of over 30 states to redesign or replace their Medicaid information technology systems—an effort that states are undertaking, in part, to facilitate their efforts to comply with a multitude of federal requirements, only one of which is T-MSIS.<sup>52</sup> A group representing state Medicaid directors also noted that state efforts to implement T-MSIS have been hindered by unclear and changing federal requirements. According to this group,

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<sup>51</sup>The 12 states that participated in the pilot were Arizona, Arkansas, California, Michigan, Minnesota, New Jersey, New Mexico, North Carolina, Oregon, Tennessee, Texas, and Washington. Of the pilot states, Arkansas, North Carolina, Tennessee, and Washington are the only states currently submitting T-MSIS data. The other states submitting T-MSIS data are Alabama, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Nevada, New Hampshire, Pennsylvania (CHIP only), Rhode Island, South Carolina, and Virginia.

<sup>52</sup>For example, state information technology systems must be capable of establishing a coordinated eligibility and enrollment process for Medicaid, CHIP, and health insurance exchanges.



CMS's ongoing revisions to T-MSIS requirements have created challenges and costs for states.<sup>53</sup>

In addition to uncertainty regarding states' implementation of T-MSIS, CMS has not fully developed its plans for assessing and ensuring the quality of state data and, according to agency officials, is still trying to determine the best way to summarize and communicate what it has learned about the data's quality to internal users and to states. According to CMS officials, the agency is producing data quality reports for internal users and anticipates sharing such reports with the public in 2017. While CMS officials identified seven broad priority areas for assessing the quality of the data—eligibility, expenditures, all utilization, FFS utilization, managed care utilization, providers, and third party liability—they have not yet delineated priorities within these areas for further review or identified specific data variables for priority validation—associated with improper payments or otherwise. Nonetheless, CMS officials noted that they have taken some steps to address the quality of state data. For example, in addition to the automated front-end data quality checks, the agency's contractor has developed 2,000 quality measures to determine whether data are within expected ranges. For instance, if a state's data suggested a Medicaid population that is 70 percent male, CMS would examine the data further as its data indicate the Medicaid population is predominantly female. CMS officials emphasized that they continue to develop processes to ensure data quality and expect to identify trends in the data that would allow them to develop new quality checks or determine which checks are no longer relevant. Without fully developing, implementing, and expediting efforts to assess the quality of T-MSIS data, CMS cannot ensure the accuracy and completeness of T-MSIS data that states submit.

CMS's plans for using T-MSIS to oversee states' Medicaid programs also remain preliminary, and the agency has not established specific time frames for their use. Officials report that the agency is currently examining available state T-MSIS data to identify any problematic trends and developing analytic tools designed to assist with monitoring and

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<sup>53</sup>See National Association of Medicaid Directors' Letter to the U.S. Senate Committee on Finance on Data Streamlining and Reporting, Jan. 8, 2016. <http://medicaiddirectors.org/wp-content/uploads/2016/01/NAMD-Response-to-SFC-data-request-160108-1.pdf>, accessed September 29, 2016. According to this group, states are also concerned about the public availability of the T-MSIS data they submit and how CMS will account for significant variability between states' populations and programs.

oversight. For example, CMS's Center for Program Integrity has begun to crosswalk T-MSIS provider data to Medicare data to develop an algorithm to assist with program integrity efforts. Additionally, CMS established the Division of Business and Data Analysis in 2015 to lead analysis and dissemination of Medicaid and CHIP data. Such efforts include working with states on improving the quality of their T-MSIS data and to support other CMS offices' use of data for program management and monitoring. According to CMS officials, the improved data will be used by CMS, states, and researchers for program monitoring, policy implementation, improving beneficiary health care, and lowering costs. Officials reported they anticipate that as more states submit T-MSIS data, and both states and CMS gain more experience with the process, the agency will develop additional and more complex uses of T-MSIS for program oversight purposes.

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## Conclusion

The continuing increase in federal Medicaid improper payments—estimated at over \$36 billion in fiscal year 2016—underscores the need for improved program oversight. We and others have expressed long-standing concerns about the completeness, accuracy, and timeliness of available Medicaid data, and the effect of these insufficiencies on CMS's ability to ensure the fiscal integrity of the program. CMS's continued reliance on inaccurate, incomplete, and untimely data, and the ongoing uncertainty about the scope and timing of its remedial actions, is inconsistent with federal internal control standards. As a steward of the program, CMS must take immediate steps to ensure the appropriate use of scarce federal and state dollars.

CMS acknowledges the need for improved Medicaid data and is taking actions aimed at improving available data. Thus far, CMS actions have focused on guidance and regulations, continued oversight of program integrity, and improved reporting of specific expenditures, such as supplemental payments. It is unknown whether these actions, while important, will significantly improve CMS's ability to oversee this complex and growing program. In the longer term, CMS cites T-MSIS as its primary effort to streamline and improve data. T-MSIS includes aspects aimed at improving the quality of state data available to CMS, yet uncertainty remains as to when these data will be available from all states; how CMS will ensure their quality; or how CMS will use these data for oversight purposes. Without an improved focus on ensuring the accuracy of data—and setting priorities for the data that are most likely to

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improve program oversight—the effectiveness of T-MSIS cannot be assured.

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## Recommendation for Executive Action

We recommend that the Administrator of CMS take immediate steps to assess and improve the data available for Medicaid program oversight, including, but not limited to, T-MSIS. Such steps could include

- refining the overall data priority areas in T-MSIS to better identify those variables that are most critical for reducing improper payments, and
- expediting efforts to assess and ensure the quality of these T-MSIS data.

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its written comments, HHS concurred with our recommendation and acknowledged the importance of having robust, timely, and accurate data to ensure the highest financial and program performance in the Medicaid program. HHS highlighted aspects of T-MSIS aimed at improving state data, which would strengthen program monitoring and oversight, policy implementation, and provide a framework for identifying potential areas of concern so that additional efforts may be taken that could reduce future instances of potential fraud, waste, and abuse. Further, HHS noted its ongoing efforts to work with states to ensure compliance with T-MSIS reporting requirements, reduce reporting errors, and improve the quality of their data submissions. HHS also provided a technical comment, which we incorporated. HHS's comments are reproduced in appendix I.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report 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 staff members have any questions, please contact me at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of

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Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix II.



Carolyn L. Yocom  
Director, Health Care

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*List of Requesters*

The Honorable Thomas Carper  
United States Senate  
The Honorable Orrin Hatch United States Senate  
The Honorable Claire McCaskill  
United States Senate  
The Honorable Ron Wyden  
United States Senate

The Honorable Frank Pallone, Jr.  
House of Representatives  
The Honorable Fred Upton  
House of Representatives

# 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 20 2016

Carolyn L. 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: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*" (GAO-17-173).

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

Sincerely,

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: PROGRAM OVERSIGHT HAMPERED BY DATA CHALLENGES. UNDERSCORING NEED FOR CONTINUED IMPROVEMENTS (GAO-17-173)**

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 data collection systems. HHS takes seriously its role in data collection for Medicaid program management and oversight.

HHS understands the importance of robust, timely, and accurate data to ensure the highest financial and program performance in Medicaid. For example, HHS staff review CMS-64 expenditure reports and can request additional documentation from the state and defer federal funds as necessary until the requested documentation is provided to support the claim. Furthermore, HHS conducts annual financial management reviews, which allow for a more intensive review of state expenditures and include an analysis of the funding source and appropriateness of a payment.

In addition, HHS has been working with states to implement changes to the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS or T-MSIS. As part of the transition to T-MSIS, HHS has strengthened its reporting requirements by standardizing definitions, expanding the data being collected, adding data quality enhancements, and improving the timeliness of data submission by moving from quarterly to monthly state data submissions. Specifically, HHS has expanded the data that states are required to submit, including new files on managed care plans, providers, and third party liability, and is providing states with guidance on the definitions and specifications of these new requirements. Additionally, T-MSIS includes new front-end edits and back-end data quality checks, allowing states to see the results of the front-end edits and resolve these errors in a timely way, representing a major enhancement over MSIS.

Currently, HHS is working to transition all states to T-MSIS. HHS is providing intensive one-on-one technical assistance to all states and expects states to continue submitting timely and accurate monthly eligibility and enrollment data. In addition, HHS will continually provide ongoing support to states in order to address key issues and share best practices on file submissions, data quality and reporting through all-state webinars and other activities.

Having access to more robust, timely and accurate data via T-MSIS will strengthen program monitoring, policy implementation, oversight of Medicaid and CHIP programs, and will enhance the ability to identify potential fraud, waste and abuse, and improve program efficiency. HHS and states will have greater insight into how to improve these programs from a national perspective using a consistent data set. T-MSIS will also reduce administrative burden on states by streamlining the reporting process and reducing the number of reports and data requests HHS requires. The enhanced data available from T-MSIS will support improved program and financial management as well as more robust evaluations of demonstration programs.

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: MEDICAID: PROGRAM OVERSIGHT HAMPERED BY DATA CHALLENGES, UNDERSCORING NEED FOR CONTINUED IMPROVEMENTS (GAO-17-173)**

**GAO Recommendation**

Refine the overall data priority areas in T-MSIS to better identify those variables that are most critical for reducing improper payments.

**HHS Response**

HHS concurs with this recommendation. HHS is working to refine T-MSIS provider, enrollment, eligibility, claims, and encounter data elements, focusing specifically on data elements critical to informing potential improper payments, such as national provider identification (NPI) number and third party liability. While T-MSIS alone cannot reduce improper payments, it will provide the framework to identify potential areas of concern so that other efforts may be taken in an attempt to reduce future improper payments. As such, HHS is working to verify alignment of the T-MSIS data elements with the Medicaid improper payment measurement so that T-MSIS data is able to effectively be used to measure Medicaid improper payments and identify areas of concern. HHS is continually working with states to ensure compliance with HHS reporting requirements through T-MSIS, which will assist in program integrity efforts.

**GAO Recommendation**

Expedite efforts to assess and ensure the quality of these T-MSIS data.

**HHS Response**

HHS concurs with this recommendation. HHS has made major enhancements to the way it collects and assesses the quality of T-MSIS data submitted by states. HHS has built in front-end edits and over 2,000 back-end data quality checks into T-MSIS. These enhancements will assist states and users of the data with more timely information regarding data quality. Given that this is a new data set, states are working to report more consistently and HHS will assist states in these efforts to reduce reporting errors and improve the quality of the data.



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# Appendix II: GAO Contact and Staff Acknowledgements

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## GAO Contact

GAO Contact: Carolyn L. Yocom, (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Susan Anthony (Assistant Director), Manuel Buentello (Analyst-in-Charge), Ricky Harrison Jr., and Kate Nast Jones made key contributions to this report. Also contributing were Sandra George and Drew Long.

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# Appendix III: Accessible Data

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## Data Table

### 1) State Medicaid Management Information System (MMIS) data

- States are required to maintain data on Medicaid enrollees, health care services covered, and expenditures in their respective MMIS.
- States use these data for management and oversight of their Medicaid program operations and costs.

#### a) CMS-64 data

- The CMS-64 data are derived from MMIS and contain Medicaid program benefit costs and administrative expenses aggregated at the state level.
- States submit expenditures quarterly to receive federal reimbursement for their Medicaid programs.

#### b) Medicaid Statistical Information System (MSIS) data

- MSIS is a Medicaid eligibility and claims data set with information on Medicaid enrollees, including eligibility, paid claims, and encounter data.
- CMS uses MSIS data for oversight purposes including Medicaid health care research and evaluation.

#### i) Medicaid Analytic eXtract (MAX) data

- MAX data include Medicaid eligibility, utilization and payment information for all individuals whether or not they used any Medicaid services in a given calendar year.
- CMS derives MAX data from MSIS data and makes them available to support external researchers in their analysis of the Medicaid program.

#### ii) MSIS Annual Person Summary data

- MSIS Annual Person Summary data are aggregate information on services and expenditures for each beneficiary for a given year and are derived from MSIS data. Because the data are condensed, they do not have the same level of detail as do MSIS data.

- CMS makes MSIS Annual Person Summary File data available to support external researchers in their analyses of the Medicaid program.

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## Agency Comment Letter

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

#### Page 1

Carolyn L. 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: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements" (GAO-17-173).

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

Sincerely,

Jim R. Esquea

Assistant Secretary for Legislation

Attachment

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Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES <HHS> ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED; MEDICAID; PROGRAM OYERSIGHT HAMPER ED BY DATA CHALLENGES. UNDERSCORING NEED FOR CONTINUED IMPROVEMENTS GA0-17-173

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 data collection systems. HHS takes seriously its role in data collection for Medicaid program management and oversight.

HHS understands the importance of robust, timely, and accurate data to ensure the highest financial and program performance in Medicaid . For example, HHS staff review CMS-64 expenditure reports and can request additional documentation from the state and defer federal funds as necessary until the requested documentation is provided to support the claim.

Furthermore, HHS conducts annual financial management reviews, which allow for a more intensive review of state expenditures and include an analysis of the funding source and appropriateness of a payment.

In addition, HHS has been working with states to implement changes to the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS or T-MSIS. As part of the transition to T-MSIS, HHS has strengthened its reporting requirements by standardizing definitions, expanding the data being collected, adding data quality enhancements , and improving the timeliness of data submission by moving from quarterly to monthly state data submissions. Specifically, HHS has expanded the data that states are required to submit, including new files on managed care plans, providers, and third party liability, and is providing states with guidance on the definitions and specifications of these new requirements. Additionally, T-MSIS includes new front-end edits and back-end data quality checks, allowing states to see the results of the front-end edits and resolve these errors in a timely way, representing a major enhancement over MSIS.

Currently, HHS is working to transition all states to T-MSIS. HHS is providing intensive one-on- one technical assistance to all states and

expects states to continue submitting timely and accurate monthly eligibility and enrollment data. In addition, HHS will continually provide ongoing support to states in order to address key issues and share best practices on file submissions, data quality and reporting through all-state webinars and other activities.

Having access to more robust, timely and accurate data via T-MSIS will strengthen program monitoring, policy implementation, oversight of Medicaid and CHIP programs, and will enhance the ability to identify potential fraud, waste and abuse, and improve program efficiency. HHS and states will have greater insight into how to improve these programs from a national perspective using a consistent data set. T-MSIS will also reduce administrative burden on states by streamlining the reporting process and reducing the number of reports and data requests HHS requires. The enhanced data available from T-MSIS will support improved program and financial management as well as more robust evaluations of demonstration programs. GAO's recommendations and HHS' responses are below.

### Page 3

#### **GAO Recommendation**

Refine the overall data priority areas in T-MSIS to better identify those variables that are most critical for reducing improper payments.

#### **HHS Response**

HHS concurs with this recommendation. HHS is working to refine T-MSIS provider, enrollment, eligibility, claims, and encounter data elements, focusing specifically on data elements critical to informing potential improper payments, such as national provider identification (NPI) number and third party liability. While T-MSIS alone cannot reduce improper payments, it will provide the framework to identify potential areas of concern so that other efforts may be taken in an attempt to reduce future improper payments. As such, HHS is working to verify alignment of the T-MSIS data elements with the Medicaid improper payment measurement so that T-MSIS data is able to effectively be used to measure Medicaid improper payments and identify areas of concern. HHS is continually working with states to ensure compliance with HHS reporting requirements through T-MSIS, which will assist in program integrity efforts.

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**GAO Recommendation**

Expedite efforts to assess and ensure the quality of these T-MSIS data.

**HHS Response**

HHS concurs with this recommendation. HHS has made major enhancements to the way it collects and assesses the quality of T-MSIS data submitted by states. HHS has built in front-end edits and over 2,000 back-end data quality checks into T-MSIS. These enhancements will assist states and users of the data with more timely information regarding data quality. Given that this is a new data set, states are working to report more consistently and HHS will assist states in these efforts to reduce reporting errors and improve the quality of the data.

Page 4

Page 19, first bullet, first sentence

HHS recommends that "billing" be added after "abusive" and "schemes" should be replaced with "practices. "

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# Related GAO Products

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The following are selected GAO products pertinent to the issues discussed in this report. Other products may be found at GAO's web site at [www.gao.gov](http://www.gao.gov).

*Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments.* [GAO-16-108](#). Washington, D.C.: February 5, 2016.

*Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods.* [GAO-16-195T](#). Washington, D.C.: November 3, 2015.

*Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds.* [GAO-16-53](#). Washington, D.C.: October 16, 2015.

*Medicaid: Key Issues Facing the Program.* [GAO-15-677](#). Washington, D.C.: July 30, 2015.

*Medicaid: Additional Reporting May Help CMS Oversee Prescription-Drug Fraud Controls.* [GAO-15-390](#). Washington, D.C.: July 8, 2015.

*Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care.* [GAO-15-481](#). Washington, D.C.: May 29, 2015.

*Medicaid: CMS Oversight of Provider Payments is Hampered by Limited Data and Unclear Policy.* [GAO-15-322](#). Washington, D.C.: April 10, 2015.

*High-Risk Series: An Update.* [GAO-15-290](#). Washington, D.C.: February 11, 2015.

*Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts.* [GAO-15-208](#). Washington, D.C.: January 28, 2015.

*Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures.* [GAO-14-341](#). Washington, D.C.: May 19, 2014.

*Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection.* [GAO-14-627](#). Washington, D.C.: July 29, 2014.

*Medicaid: Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight.* [GAO-14-817T](#). Washington, D.C.: July 29, 2014.

*Medicaid: More Transparency and Accountability for Supplemental Payments are Needed.* [GAO-13-48](#). Washington, D.C.: November 26, 2012.

*Medicaid: Data Sets Provide Inconsistent Picture of Expenditures.* [GAO-13-47](#). Washington, D.C.: October 29, 2012.

*Medicaid: States Reported Billions More in Supplemental Payments in Recent Years.* [GAO-12-694](#). Washington, D.C.: July 20, 2012.

*National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States.* [GAO-12-627](#). Washington, D.C.: June 14, 2012.

*Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement.* [GAO-11-293R](#). Washington, D.C.: April 5, 2011.



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