



December 2017

MEDICAID

Further Action Needed to Expedite Use of National Data for Program Oversight

Accessible Version

GAO Highlights

Highlights of [GAO-18-70](#), a report to congressional requesters

Why GAO Did This Study

GAO and others have identified insufficiencies in state-reported Medicaid data that affect CMS's ability to oversee the program effectively. Recent increases in improper payments—estimated at \$36.7 billion in fiscal year 2017—exacerbate concerns about program oversight.

CMS officials identified the T-MSIS initiative, which began in 2011, as its main effort to improve Medicaid data, and cited aspects of T-MSIS aimed at improving the scope and quality of state-reported data. GAO reported in January 2017 that it is unclear when T-MSIS data will be available from all states; how CMS will ensure data quality; or how the data will be used to enhance oversight of Medicaid.

GAO was asked to review states' experiences with T-MSIS implementation and planned uses of T-MSIS data. This report examines (1) states' experiences regarding T-MSIS implementation, and (2) challenges to CMS's and states' use of T-MSIS data for oversight. GAO reviewed federal laws, guidance, and internal control standards; reviewed documents and interviewed officials from eight states, selected based on their T-MSIS reporting status, location, program expenditures, and other factors; and interviewed CMS officials, CMS contractors, and individuals involved with other states' T-MSIS efforts.

What GAO Recommends

GAO recommends that CMS (1) improve T-MSIS's completeness and comparability to expedite its use, and (2) articulate a specific oversight plan. The Department of Health and Human Services concurred with GAO's recommendations.

View [GAO-18-70](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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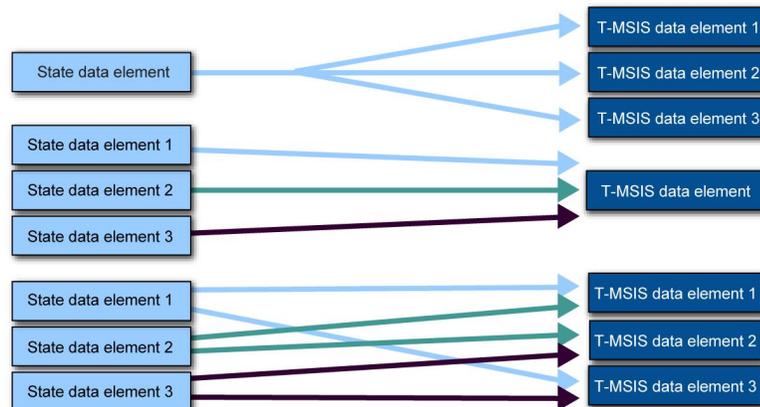
MEDICAID

Further Action Needed to Expedite Use of National Data for Program Oversight

What GAO Found

As of November 2017, 49 states had begun reporting Transformed Medicaid Statistical Information System (T-MSIS) data—a significant increase from 18 states reporting these data one year earlier. All eight states GAO reviewed identified converting their data to the T-MSIS format on an element-by-element basis as the main challenge in their reporting efforts. For some data elements, states had to expand or collapse their data to match the T-MSIS format.

Examples of Possible Relationships in Converting State Data Elements and T-MSIS Elements



Source: GAO analysis of state information. | GAO-18-70

With the continued implementation of T-MSIS, the Centers for Medicare & Medicaid Services (CMS) has taken an important step toward developing a reliable national repository for Medicaid data. However, data challenges have hindered states' and CMS's use of the T-MSIS data for oversight.

- None of the six selected states reporting T-MSIS data in August 2017 was reporting complete data. These states said that certain unreported elements were contingent on federal or state actions, and others were not applicable to the state's Medicaid program. States did not always specify in their documentation whether they planned to report elements in the future or when they would report complete data.
- Six of eight selected states expressed concerns about the comparability of T-MSIS data across states. Further, all states were interested in CMS facilitating information sharing among states. CMS has not compiled and shared information about states' data limitations, which would help states accurately compare their T-MSIS data to other states' T-MSIS data.

CMS has taken steps for the initial use of T-MSIS data, but does not have a plan or associated timeframes for using these data for oversight. As a result, important CMS goals for T-MSIS, such as reducing states' reporting burden and enhancing program integrity activities, are not being fully realized.

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Abbreviations

| | |
|---------|--|
| CMS | Centers for Medicare & Medicaid Services |
| DME | durable medical equipment |
| HHS | Department of Health and Human Services |
| HHS-OIG | Department of Health and Human Services' Office of Inspector General |
| MCO | managed care organization |
| MMIS | Medicaid Management Information System |
| MSIS | Medicaid Statistical Information System |
| NPI | National Provider Identifier |
| T-MSIS | Transformed Medicaid Statistical Information System |

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December 8, 2017

Congressional Requesters:

Medicaid—the joint federal-state health financing program estimated to cover over 73 million low-income and medically needy individuals in fiscal year 2017—allows states significant flexibility to design and implement their programs within broad federal parameters.¹ While this flexibility has allowed states to fashion their programs based on their unique needs, it also complicates oversight. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, has a critical role in monitoring states' compliance with federal requirements, including ensuring that federal Medicaid payments are made appropriately. To help inform its oversight, CMS relies on data that are submitted by states. For example, for expenditure and utilization data that can be linked to individual enrollees, states historically submitted data to be incorporated into CMS's Medicaid Statistical Information System (MSIS) data.²

We and others have reported that insufficiencies in available Medicaid data, including MSIS data, have affected CMS's ability to ensure proper payments and beneficiaries' access to care.³ These concerns are not new; however, recent trends in improper payments have exacerbated concerns about Medicaid oversight. In particular, of the \$596 billion in federal and state Medicaid expenditures in fiscal year 2017, improper

¹Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid*, (Washington, D.C.: 2017). For the purposes of this report, we include the District of Columbia as a state.

²MSIS and other state-reported data often originate from states' Medicaid Management Information Systems (MMIS), which are claims processing and information retrieval systems that support the administration of the program. See 42 C.F.R. § 433.111(b) (2016). States can 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 operations. See 42 U.S.C. §§ 1396b(a)(3)(A)(i), (B).

³See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017). Department of Health and Human Services, Office of Inspector General, *Office of Inspector General's FY 2015 Top Management and Performance Challenges Facing the Department of Health and Human Services*, accessed October 3, 2017, <https://oig.hhs.gov/reports-and-publications/top-challenges/2015/challenge01.asp>.

payments were an estimated \$36.7 billion, a significant increase from the estimated \$14.4 billion in improper payments in fiscal year 2013.⁴

CMS has acknowledged the need for improved Medicaid data. The Transformed Medicaid Statistical Information System (T-MSIS) initiative is the agency's primary effort, conducted jointly with states, to improve its collection of Medicaid expenditure and utilization data, and replace MSIS.⁵ CMS officials cite aspects of T-MSIS that are designed to broaden the scope and improve the quality of state-reported data, as well as the data's usefulness for states. For example, T-MSIS is intended to include data not previously reported by states, such as unique provider identification numbers and information on third-party liability, which could be used to help enhance CMS and states' program oversight. T-MSIS also includes automated quality checks that should improve the quality of data that states report.

In a January 2017 report, we examined CMS efforts to implement T-MSIS and concluded that uncertainty existed with respect to when all states would report T-MSIS data; how CMS will ensure the quality of these data; and how CMS will use them for oversight purposes. You asked us to examine states' experiences regarding T-MSIS implementation, including obstacles they have faced in reporting quality data, and their planned uses of these data for oversight. In this report, we examine

1. states' experiences regarding the implementation of T-MSIS, including CMS's actions to facilitate states' efforts; and
2. challenges to CMS's and states' use of T-MSIS data for oversight.

To examine states' experiences regarding the implementation of T-MSIS—including CMS's actions to facilitate their efforts—we reviewed

⁴An 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 (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note.

⁵In addition to the T-MSIS initiative, CMS has taken other actions to improve data reporting and to enhance available data, such as issuing new regulations for managed care plans and for more targeted financial consequences for states that do not comply with data submission requirements. T-MSIS also includes state-reported data on the State Children's Health Insurance Program, which is a joint federal-state program for children with a household income above the threshold for Medicaid eligibility.

federal laws and guidance, and interviewed CMS officials and contractors who assisted the agency with T-MSIS implementation.⁶ We reviewed CMS documentation of the number of states reporting T-MSIS data and of its actions to support states' T-MSIS implementation efforts. We also selected a non-generalizable sample of eight states for further review: Louisiana, Michigan, Minnesota, North Carolina, Pennsylvania, Utah, Virginia, and Washington. We selected these states based on variation in their T-MSIS reporting status, geographic location, program expenditures, use of Medicaid managed care programs, and participation in CMS's T-MSIS pilot program.⁷ For each selected state, we reviewed relevant documents, and interviewed officials about their experiences reporting T-MSIS data and CMS's efforts to assist them. To supplement the information provided by our selected states, we also interviewed individuals who were identified through background research as having experience with other states' T-MSIS reporting efforts. We also reviewed prior GAO reports on Medicaid data and reports published by other entities, such as the HHS Office of Inspector General (HHS-OIG).⁸

To examine challenges to CMS's and states' use of T-MSIS data for oversight, we reviewed CMS guidance, selected states' documentation of T-MSIS reporting efforts, and federal internal control standards.⁹ We also

⁶States' involvement in implementing T-MSIS has varied, with some states participating in the planning and testing of the T-MSIS design and development. All states, however, are responsible for implementing systems—or system changes—that allow them to report data in the T-MSIS format. We interviewed the following CMS contractors: Nuna, which assisted CMS in building the technical infrastructure to T-MSIS; NewWave Telecom & Technologies Inc., which provided technical assistance to states in reporting T-MSIS data; and Mathematica Policy Research, which is examining T-MSIS data quality.

⁷We based our selection on states' T-MSIS reporting status as of February 2017. At that time, four states (North Carolina, Pennsylvania, Virginia, and Washington) were reporting T-MSIS data, while the other four (Louisiana, Michigan, Minnesota, and Utah) were not. In addition, CMS began implementing T-MSIS as a pilot program in 12 states, and four of our selected states—Michigan, Minnesota, North Carolina, and Washington—participated in that program.

⁸HHS-OIG, *Early Outcomes Show Limited Progress For The Transformed Medicaid Statistical Information System*, OEI-05-12-00610 (Washington, D.C.: September 2013). More recently, the HHS-OIG identified technological problems during data testing and competing priorities for states' IT resources as factors affecting states' ability to report T-MSIS in a timelier manner. See HHS-OIG, *Status Update: T-MSIS Data Not Yet Available for Overseeing Medicaid*, OEI-05-15-00050 (Washington, D.C.: June 2017).

⁹See 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.

interviewed officials from CMS and selected states regarding their plans to use these data for oversight. To assess the completeness of the T-MSIS data that selected states were reporting, we analyzed state documents regarding unreported T-MSIS data elements and their plans to report them in the future. These documents, which states submit to CMS, are known as Addendum Bs. To assess the reliability of the Addendum B data, we compared them with related documentation, such as CMS guidance, and with information from interviews with knowledgeable CMS and state officials. We also assessed the data for duplicate values and clarified inconsistencies we identified. We confirmed with state officials that their documents reflected unreported T-MSIS data elements as of August 2017.¹⁰ We determined that these data were sufficiently reliable for our purposes.

We conducted this performance audit from December 2016 through December 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

CMS intends for the T-MSIS initiative to provide a national data repository that would support federal and state program management, financial management, and program integrity activities, among other functions.¹¹ T-MSIS is also intended to benefit states by reducing the number of reports CMS requires them to submit, and by improving program efficiency by allowing states to compare their data with other states' data in the national repository or with information in other CMS repositories, including

¹⁰One of our selected states—North Carolina—provided subsequent documentation on their unreported data elements as of September 2017, which we incorporated into this report.

¹¹Centers for Medicare & Medicaid Services, State Medicaid Director Letter #13-004 *Re: Transformed Medicaid Statistical Information System (T-MSIS) Data*, (Baltimore, Md.: Aug. 23, 2013). The T-MSIS 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.

Medicare data.¹² For example, CMS intends to use T-MSIS data for reports that states are currently required to submit, such as Early and Periodic Screening, Diagnostic, and Treatment Program reports.¹³

T-MSIS is designed to capture significantly more data from states than is the case with MSIS, thereby collecting data not previously reported that should provide CMS and states with information to enhance their oversight efforts.¹⁴ T-MSIS includes the five data files that were collected through MSIS: an eligibility file and four claims files (inpatient, long-term care, pharmacy, and other). The scope of data to be collected from these five previously defined MSIS files has expanded to include more detailed information on enrollees, such as their citizenship, immigration, and disability status; and expanded diagnosis and procedure codes associated with their treatments.

Additionally, T-MSIS requires states to report three new data files on (1) providers, (2) third-party liability, and (3) managed care organizations (MCO).

- 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 identifiers can assist CMS and state oversight by providing

¹²Medicare is the federal health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease.

¹³States 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 benefit on the CMS-416. CMS uses the CMS-416 to assess the effectiveness of state programs for children.

¹⁴Federal law has long required states to report to CMS fee-for-service claims and managed care enrollee encounter data as specified by the Secretary of HHS. See, e.g., Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4753, 111 Stat. 251, 525 (codified as amended at 42 U.S.C. § 1396b(r)(1)(F)). In 2010, Congress added to this provision a requirement for states to report additional data elements that the Secretary deems necessary for program integrity, oversight and administration, which states may report through T-MSIS. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6504, 124 Stat. 119, 776 (2010). To enforce these requirements, CMS may withhold federal matching payments for the use, maintenance or modification of automated data systems from states that fail to report required data. See 42 C.F.R. § 433.120 (2016). Additionally, CMS may withhold federal matching payments for medical assistance to managed care enrollees for whom states fail to report required encounter data. See 42 U.S.C. § 1396b(i)(25) and 42 C.F.R. § 438.818 (2016).

information 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, or other potential sources of funds that could reduce Medicaid's expenditures. Medicaid is generally the payer of last resort, meaning if Medicaid enrollees have another source of health care coverage, that source should pay, to the extent of its liability, before Medicaid does.¹⁵ Information on beneficiaries' other sources of coverage could help ensure that Medicaid pays only those expenditures for which it is liable.
- 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 which MCOs are reporting encounter data as required, this file could help CMS's oversight by allowing the agency to identify excess plan profits and volatility of expenditures for some beneficiary groups across states.¹⁶

In total, T-MSIS includes approximately 1,400 data elements, according to CMS. Many of these elements, however, have content that is used in more than one of the eight T-MSIS files. For example, the element "DATE OF BIRTH" is required in five T-MSIS files—Eligibility, Claim Inpatient, Claim Long-term Care, Claim Prescription, and Claim Other.¹⁷ CMS requires states to report all T-MSIS elements that are applicable to their programs, and has worked closely with states to facilitate their efforts to

¹⁵See GAO, *Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts*, [GAO-15-208](#) (Washington, D.C.: Jan. 28, 2015). According to agency officials, the third-party liability file is intended to include other sources liable for funding coverage, such as tort settlements, worker's compensation, and medical coverage under automobile insurance.

¹⁶State contracts with Medicaid MCOs must provide for the maintenance of enrollee encounter data and submission of such data to the state at a frequency and level of detail specified by the Secretary of HHS. 42 U.S.C. § 1396b(m)(2)(A)(xi). See also 42 C.F.R. § 438.242(c) (2016).

¹⁷In this example, the content of the specific element would be the same across all five files, but is designated by a different number for each file: ELG024 (Eligibility), CIP175 (Claim Inpatient file), CLT126 (Claim Long-term care file), CRX066 (Claim Prescription) and COT108 (Claim Other file).

report these data.¹⁸ For example, before CMS approves a state for reporting T-MSIS data, states must complete a number of activities, including developing detailed work plans and completing a series of data testing phases.¹⁹ For a state to meet CMS's requirements for submitting T-MSIS data, it must report data for all eight files, but not necessarily all elements within each file.

In addition, T-MSIS includes aspects aimed at improving the timeliness and accuracy of data submitted by states. For example, CMS requires states to report T-MSIS data monthly, rather than quarterly, as was the case with MSIS. Regarding data accuracy, T-MSIS includes approximately 2,800 automated quality checks that provide states with feedback on data format and consistency, according to CMS; this is in contrast to MSIS, which had relatively few automated checks. Other quality checks are to ensure logical relationships across T-MSIS files.

Both we and the HHS-OIG have previously recommended that CMS take steps to address the quality of T-MSIS data. In our January 2017 report, we recommended that CMS take immediate steps to assess and improve T-MSIS data.²⁰ As part of that effort, we noted that CMS could refine their T-MSIS data priority areas to identify those that are critical for reducing improper payments and expedite efforts to assess and ensure their quality. CMS agreed with our recommendation, but as of September 2017, the agency had not implemented it. More recently, the HHS-OIG reported that CMS and states continue to have concerns regarding the completeness and reliability of T-MSIS data, echoing concerns raised in its 2013 review of CMS's T-MSIS pilot program.²¹ The HHS-OIG noted it

¹⁸For example, a state that does not offer Medicaid coverage through MCOs or have Medicaid waiver programs would not have data to report on those related T-MSIS data elements. In addition, CMS officials told us that some T-MSIS data elements, such as managed care fax numbers and email addresses, are optional and can be populated at the discretion of the state.

¹⁹These testing phases are referred to as Pre-operational Readiness Testing and Operational Readiness Testing. During these phases, CMS works with states to address issues regarding data format and testing to ensure compatibility with CMS's system, among other issues, and states must also document which data elements they will submit on initial T-MSIS submission and estimate when they will submit additional elements. Once a state successfully completes these testing phases, CMS sends the state an approval letter, and the state can begin to report T-MSIS data.

²⁰See [GAO-17-173](#).

²¹See HHS-OIG, OEI-05-12-00610; and HHS-OIG, OEI-05-15-00050.

was concerned that CMS and states would delay further efforts rather than assign the resources needed to address the outstanding challenges, and reaffirmed its 2013 recommendation that CMS establish a deadline for when T-MSIS data will be available for program analysis and other management functions.

Despite Challenges Converting State Data to the T-MSIS Format, Nearly All States are Reporting T-MSIS Data, and CMS Has Shifted Its Focus to Improving Data Quality

Despite challenges converting their data to the T-MSIS format, most states were reporting T-MSIS data as of November 2017, representing significant progress over the past year. With most states reporting, CMS has shifted its efforts to working with states to improve the quality of T-MSIS data.

Overall, 49 States Are Reporting T-MSIS Data; Selected States Identified Converting their Data into the T-MSIS Format as a Significant Reporting Challenge

As of November 2017, 49 states have begun reporting T-MSIS data, a significant increase from the 18 states that had started reporting these data in October 2016. These reporting states represent over 97 percent of the 2017 Medicaid population nationwide.²² CMS officials told us that they expect all states to report T-MSIS data by 2018. (See fig. 1.)

²²GAO analysis of state and CMS data. Centers for Medicare & Medicaid Services, Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Updated Data, accessed September 25, 2017, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html>.

As of November 2017, all eight of our selected states were reporting T-MSIS data, with seven of them having begun in September 2016 or later.²³ Selected states' estimated spending a collective \$14.16 million on their efforts to report T-MSIS data from October 2011 through June 2017, ranging from approximately \$850,000 in Virginia to \$4.42 million in Minnesota.²⁴ (See table 1.) The age and scope of states' existing Medicaid Management Information Systems (MMIS) were among the factors that affected certain states' spending and timing on this effort.²⁵

²³Four of the eight selected states—Michigan, Minnesota, North Carolina, and Washington—participated in the initial T-MSIS pilot in 2011. Officials from one of these states noted that the pilot provided limited value with respect to their efforts to report T-MSIS data; however, these officials agreed that CMS gained insight from the pilot.

²⁴We were not able to identify national T-MSIS expenditures, because states are not required to report T-MSIS expenditures separately from their overall Medicaid Management Information System (MMIS) expenditures. States' reported expenditures on T-MSIS were provided by state officials through interviews. This spending represents a small portion—less than half of one percent—of their overall MMIS changes. CMS officials noted that differences in T-MSIS estimated spending could be due to state variation in systems' sophistication and resources applied to the effort. They further emphasized that the system modifications states made to report T-MSIS data had the additional benefit of improving states' ability to manage their respective programs.

²⁵Similarly, in a report examining states' changes to their Medicaid eligibility information technology systems, we found that states' changes ranged from full system replacements to more limited modifications, with the scope of a state's changes dependent on a number of factors, including the age of their system. See GAO, *Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist*, [GAO-15-169](#) (Washington, D.C.: Dec. 12, 2014).

Table 1: Selected States' T-MSIS Initial Reporting Date and Estimated Expenditures

| State | Month for initial T-MSIS reporting | Total estimated spending on T-MSIS, October 2011 through June 2017 (dollars in millions) ^a |
|----------------|------------------------------------|---|
| Louisiana | April 2017 | 1.64 |
| Michigan | April 2017 | Not available ^b |
| Minnesota | October 2017 | 4.42 |
| North Carolina | September 2016 | 1.70 |
| Pennsylvania | October 2016 | 3.30 |
| Utah | November 2017 | 1.24 |
| Virginia | May 2015 | 0.85 |
| Washington | September 2016 | 1.01 |

Source: GAO summary of state-reported data | GAO-18-70

^aState-reported total spending represents federal and state spending on the Transformed Medicaid Statistical Information System (T-MSIS) initiative. States' reported expenditures on T-MSIS were provided by state officials through interviews. According to CMS officials, differences in T-MSIS estimated spending could be due to state variation in systems' sophistication and resources applied to the effort. States can receive a 90 percent federal match for the costs associated with the development of their Medicaid Management Information System (MMIS) and a 75 percent match for the costs associated with ongoing MMIS maintenance and operations. See 42 U.S.C. §§ 1396b(a)(3)(A)(i), (B).

^bMichigan officials were not able to provide a reliable estimate of T-MSIS spending.

Mapping the data—the process by which states convert their data to the T-MSIS format on an element-by-element basis—was the primary challenge our eight selected states identified in reporting T-MSIS data. In some cases, before converting their data to the T-MSIS format, states had to obtain data they had not previously collected from other state entities, MCOs, or providers.²⁶ For example, Minnesota had to begin collecting information on denied claims from MCOs, and Utah had to collect third-party liability information from other state agencies. In addition, while some state data elements could be converted to the T-MSIS format fairly easily, because the relationships between the two were clear, the conversion of other data elements was more complicated. For example, the T-MSIS data element for male and female is “M” and “F,” respectively. Accordingly, in states that identified gender by a numeric value, “1” for male and “2” for female, the conversion to T-MSIS for this element was a fairly straightforward one-to-one relationship. However, for

²⁶Officials from certain selected states noted that their MMIS were not necessarily designed to capture detailed managed care information. For example, Virginia officials noted that their MMIS was designed for claims adjudication and not necessarily administering managed care or classifying provider types.

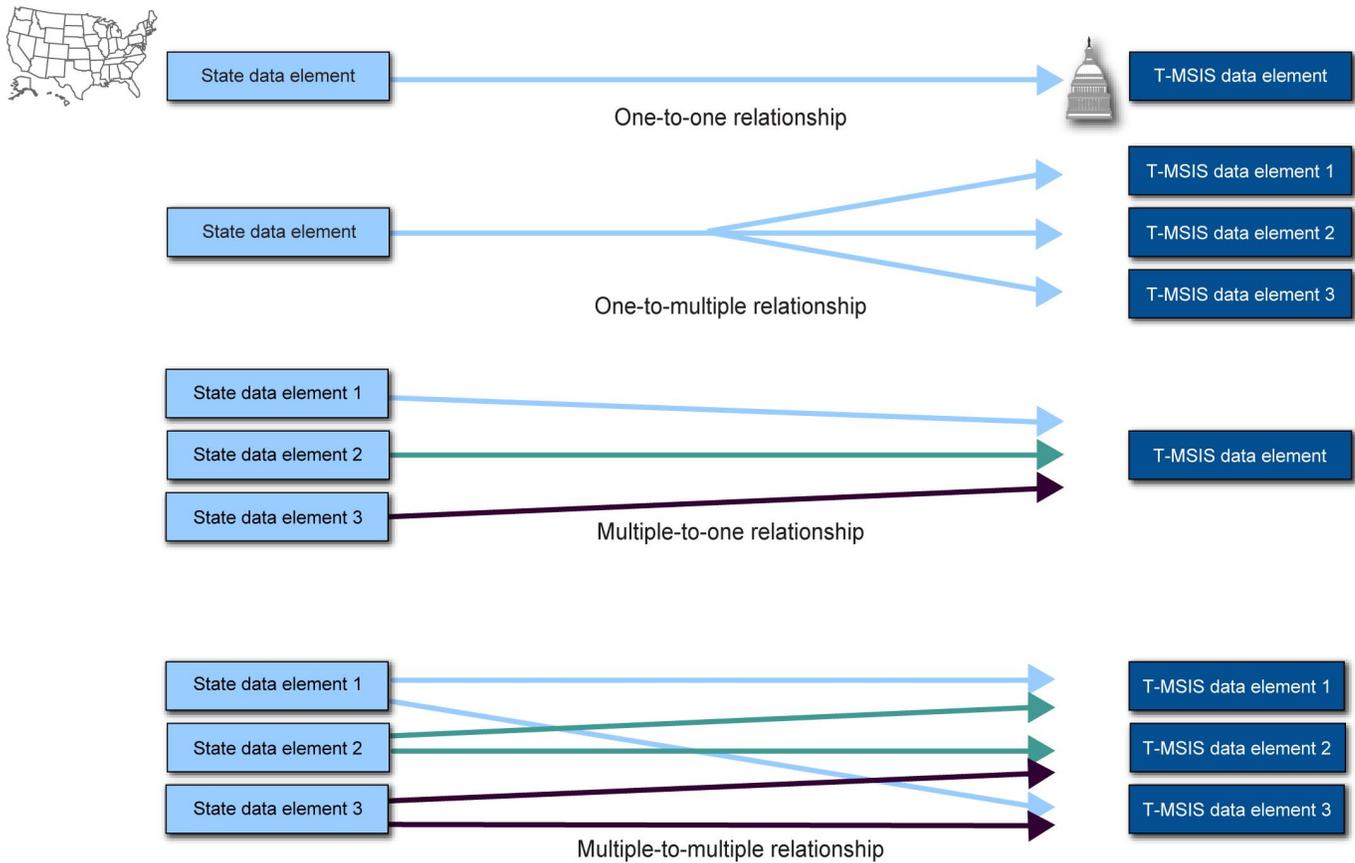
other data elements, the conversion process was more complex, requiring states to expand or collapse their data to match the T-MSIS format. (See fig. 2.) Selected states shared examples of steps they took to convert state data to the T-MSIS format.

- Louisiana officials noted that they had to map the state’s single durable medical equipment (DME) element to multiple specific T-MSIS DME elements, such as DME pharmacy or DME orthotics.²⁷
- Virginia officials said they had to combine three state ambulance service provider elements into a single T-MSIS element.

In addition, individuals who had experience with other states’ T-MSIS reporting efforts also noted that states may not have always collapsed categories in the same way. For example, one state collapsed its 109 provider categories to match T-MSIS’s 57 provider categories, according to an individual who worked with the state on this effort. This individual noted that there were 32 state provider elements that did not directly match a specific T-MSIS element, so the state grouped them all into the “other” T-MSIS element.

²⁷Similarly, Utah officials said that because T-MSIS includes more provider categories than exist in their state data, they had to determine how to refine the state’s provider categories to correspond to T-MSIS.

Figure 2: Examples of Possible Relationships in Converting State Data Elements to T-MSIS Elements



Source: GAO analysis of state information. | GAO-18-70

Note: These relationships describe various scenarios states faced in converting their data to the Transformed Medicaid Statistical Information System (T-MSIS) format on an element-by-element basis.

Changes in CMS’s data reporting requirements further complicated some states’ efforts to convert their data to the T-MSIS format, according to officials from our selected states. CMS updated the T-MSIS data dictionary—the document that defines the required T-MSIS elements and their reporting formats—twice in 2013 and again in November 2015. According to CMS officials, they updated the data dictionary to clarify and remove inconsistencies from guidance in response to feedback from states. Some of the selected states reported that the changes included in this update required considerable rework, and in some cases, delayed their T-MSIS reporting. For example, Washington officials noted that the 2015 update became available at the point it was completing a T-MSIS testing phase. Due to the rework required to comply with the new data

specifications, the state's efforts to report T-MSIS data were delayed by nearly one year. Similarly, Minnesota officials also cited rework associated with changes to the 2015 data dictionary, which contributed to delays in their efforts to report T-MSIS data.

CMS's Efforts to Support States Have Shifted from Reporting T-MSIS Data to Improving T-MSIS Data Quality

Over the past six years, CMS has relied on a variety of mechanisms to support states' efforts to report T-MSIS data.

- CMS assigned technical assistants to help states understand the T-MSIS requirements, prioritize steps to report T-MSIS data, and serve as a resource on technical issues.²⁸ The majority of selected states had positive comments about the technical assistance they received. For example, Pennsylvania officials said its technical assistant regularly met with them, answered any questions they had, and facilitated their efforts to complete T-MSIS testing.
- CMS began hosting national webinars covering a range of topics, including clarification on specific T-MSIS elements that CMS identified as challenging or subject to error, and updates on the nationwide implementation. The webinars also provided an opportunity for states to ask CMS questions about T-MSIS requirements.
- CMS established web-based avenues through which the agency could compile and disseminate information, as well as elicit questions from states and contractors. For example, CMS provided an electronic option for states to submit questions regarding policy and technical issues.
- CMS took additional steps to help states, including creating a SharePoint web site through which states are notified about changes in guidance.

With nearly all states having begun reporting T-MSIS data, CMS has shifted its efforts to improving the quality of the T-MSIS data reported, and these efforts are still evolving. For example, to provide states with immediate feedback on their reported T-MSIS data, CMS created an online "operational dashboard" for each state, which provides specific

²⁸According to CMS officials, each technical assistant is currently responsible for about 12 to 13 states, an increase from the 6 states for which each assistant was responsible when states required more reporting assistance.

information on errors in its reported data. Using information on the operational dashboard, states can identify the frequency and cause of certain errors, which facilitates their efforts to resolve them more expeditiously and to improve future submissions. All six of the selected states reporting T-MSIS data had positive comments about the value of the operational dashboard, with some of them noting that the feedback on errors was a significant improvement from their experience with MSIS, where feedback had a considerable time-lag. More recently, according to agency officials, CMS has initiated a pilot study with four states to identify anomalies in their reported data that merit further attention, obtain feedback on automated quality measures, and determine the best approach for ongoing quality review.²⁹ While work on the pilot is ongoing, CMS officials anticipate using what they learned to expand the agency's quality review to include all states.

In addition, CMS has turned to external stakeholders to evaluate the quality of T-MSIS data. Specifically, CMS has shared T-MSIS data with a Technical Expert Panel it formed to obtain feedback on inconsistencies and other quality concerns. According to CMS officials, the Technical Expert Panel focused on a preliminary set of T-MSIS data from a limited number of states. The agency officials noted that Technical Expert Panel members include individuals from HHS's Office of the Actuary, the Congressional Budget Office, and the Medicaid and CHIP Payment and Access Commission, among others. Panel participants analyzed the T-MSIS data from 11 states on the specific topics in which they have expertise. According to CMS officials, the panel is to provide its results to the agency in a summary report.

²⁹The four states participating in this pilot study are Alabama, Arkansas, Nevada, and Virginia. CMS officials noted that through its participation in the pilot, Virginia has resolved 11 data issues that were identified. CMS plans to meet with the other pilot states to resolve additional issues once CMS processes the states' next file submissions.

Data Completeness and Comparability Concerns Hinder CMS's and States' Use of T-MSIS for Oversight

Ongoing data concerns raise questions about how soon—and to what extent—T-MSIS data will be sufficient to achieve the goals of improving CMS's and states' ability to use Medicaid data for oversight. For example, none of the six selected states that were reporting T-MSIS data as of August 2017 were reporting complete data at that time. In reviewing selected states' documentation of unreported data elements, we determined that the number of unreported data elements ranged from about 80 elements to 260 elements.³⁰ Although T-MSIS includes about 1,400 data elements, the number of data elements relevant to each state varies, in part, because certain elements may not be applicable to all states and others may be populated at the state's discretion. In addition, the content of some data elements are present in more than one of the eight T-MSIS files. As a result, the number of unreported elements may overstate the extent of state efforts needed to report complete T-MSIS data.

Our selected states provided a range of reasons for not reporting T-MSIS data elements, including that certain elements were contingent on federal or state actions. In other cases, state officials indicated that data elements were too costly to report, so they would not be reporting them.³¹ We identified further examples of where certain data elements were not

³⁰Our analysis was based on documentation from five of the six selected states reporting T-MSIS data in August 2017, including documents that listed their unreported data elements and their plans to report them in the future (which are known as the states' Addendum Bs), as well as discussions with state officials. CMS officials noted that they worked with each state to maximize the reportability of states' initial T-MSIS data, and took steps to monitor which data elements were being reported across states. At the time of our study, Louisiana was in the process of updating its Addendum B, so we did not include the state in determining the range in the number of unreported data elements across selected states.

³¹With some of these data elements, such as one regarding the marital status of the beneficiary, the unreported data element was required versus optional.

applicable to states' Medicaid programs, and therefore were not required.³² (See table 2.)

³²For example, a state that does not offer Medicaid coverage through MCOs would not have data to report on those related T-MSIS data elements.

Table 2: Examples of Reasons Selected States Provided for Not Reporting Certain Transformed Medicaid Statistical Information System (T-MSIS) Data Elements as of August 2017

| States' reasons for not reporting T-MSIS data elements | Examples |
|--|--|
| Federal action needed | The six selected states reporting T-MSIS data noted that they do not report T-MSIS elements associated with the Medicare Beneficiary Identifier, which the Centers for Medicare & Medicaid Services (CMS) plans to begin issuing to Medicare beneficiaries in April 2018. ^a |
| State action needed | Virginia is developing a new Medicaid information system, which is estimated to be fully operational in 2019, according to state officials. These officials said the new system would capture data for about two-thirds of its unreported T-MSIS elements. |
| Cost of collecting data | Washington does not report certain T-MSIS elements, including elements associated with the provider responsible for admitting a patient to a hospital or other inpatient health facility, citing the costs associated with developing a separate process to do so. ^b |
| Applicability to state's Medicaid program | Three selected states—Louisiana, Pennsylvania, and Virginia—do not have a Medicaid health homes program, and therefore, do not report related T-MSIS elements. ^c |

Source: GAO analysis of information from selected states. | GAO-18-70

Note: Our analysis was based on documentation from the six selected states that were reporting T-MSIS data in August 2017, including documents that listed their unreported data elements and their plans to report them in the future (which are known as the states' Addendum Bs), as well as discussions with state officials. One of our selected states—North Carolina—provided subsequent documentation on their unreported data elements as of September 2017, which we incorporated into this table.

^aThe Medicare Beneficiary Identifier is a unique, randomly generated number designed to decrease the risk of fraud. CMS plans to use the Medicare Beneficiary Identifier to replace the Social Security-based identification number currently used on Medicare cards by January 1, 2020.

^bWashington officials noted that these data elements are not on a standard claims transaction, so they would need to collect these elements using a process other than its standard transactions.

^cAs of January 2011, states have the option to establish a health home program through which the state can provide a comprehensive system of care coordination for Medicaid beneficiaries with chronic conditions. See 42 U.S.C. § 1396w-4.

Although CMS requires states to report all T-MSIS data elements applicable to their program, CMS officials said they did not specify a reporting deadline for states, and selected states' documentation to CMS did not always include the reasons they did not report certain elements, or whether or when they planned to report them.³³ Due to the lack of clarity and completeness in selected states' documentation, we were not able to identify the reasons for all unreported data elements. However, among our selected states, Virginia's documentation more clearly specified

³³We also found that some selected states did not list all unreported data elements on their Addendum Bs. For example, two selected states did not list certain data elements related to a CMS initiative that has not been implemented.

most—but not all—of the reasons it was not reporting 260 T-MSIS elements.³⁴

- Virginia identified 167 elements that its MMIS did not capture, and noted that once the state’s new Medicaid information system is fully implemented in 2019, the state will be able to report them.
- Virginia identified 16 elements as pending other state or related actions.
- Virginia identified 18 elements as pending the implementation of HHS efforts.
- Virginia identified 53 elements as not applicable to aspects of its Medicaid program.

Without complete information from all states on unreported data elements and their plans to report them, it is unclear when—and to what extent—T-MSIS data will be available to use for oversight, which is inconsistent with federal internal control standards for using quality information to achieve objectives.³⁵

In some cases, data elements important for program oversight were not reported by two or more of the six selected states reporting T-MSIS data, limiting T-MSIS’s usefulness for oversight in these areas. (See table 3.)

³⁴For six T-MSIS data elements, we were unable to determine from Virginia’s documentation its reason for not reporting the data element. In the course of reviewing the Addendum B information with state officials, we were able to obtain additional information about the reasons for these and other unreported data elements.

³⁵See [GAO-14-704G](#).

Table 3: Examples of Selected States' Unreported Transformed Medicaid Statistical Information System (T-MSIS) Data Elements Important to Program Oversight, as of August 2017

| Unreported elements | Description, status, and importance |
|--|--|
| National provider identifiers (NPI) ^a | <p>Description: T-MSIS includes a range of NPI data elements that identify providers responsible for beneficiaries' care. These include, for example, providers billing Medicaid, prescribing medication, or admitting a beneficiary to a hospital.</p> <p>Status of selected states: Louisiana, North Carolina, Virginia, and Washington were not reporting at least one NPI data element.</p> <p>Importance: A complete list of NPI data elements can help ensure that ineligible providers are not participating in the program.</p> |
| Immigration status | <p>Description: T-MSIS includes data elements, such as an individual's immigration status, if an individual is enrolled in Medicaid pending immigration verification, and the date an individual's Medicaid eligibility waiting period ends.^b</p> <p>Status of selected states: Louisiana, Michigan, North Carolina, Virginia, and Washington were not reporting one or more immigration-related data elements.</p> <p>Importance: Complete information on immigration status can help ensure accurate beneficiary enrollment and that payments are only made for services provided to eligible beneficiaries.^c</p> |
| Supplemental payments | <p>Description: T-MSIS includes data elements for states to report provider-specific information on supplemental payments—information that CMS did not previously collect through MSIS.^d Supplemental payments— payments in addition to the regular, claims-based payments made to providers for services they provided—are a significant component of Medicaid spending, totaling about \$55 billion in 2015.</p> <p>Status of selected states: Michigan, Pennsylvania, and Virginia were not reporting all data elements on supplemental payments to providers.</p> <p>Importance: Complete information on supplemental payments can help ensure that payments meet statutory requirements for economy, efficiency, access to care and are made for covered Medicaid services.^e</p> |

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS) and selected states. | GAO-18-70

Note: Our analysis was based on documentation from the selected states, including documents that listed their unreported data elements and their plans to report them in the future (which are known as the states' Addendum Bs), as well as discussions with state officials. One of our selected states—North Carolina—provided subsequent documentation on their unreported data elements as of September 2017, which we incorporated into this table.

^aThe NPI is a national, unique 10-digit identification number assigned to health care providers.

^bStates must document the citizenship of most applicants and beneficiaries as a condition of receiving matching federal funds for their Medicaid expenditures. See 42 U.S.C. § 1396b(x). We previously reported on states' efforts to implement the federal requirement for documenting U.S. citizenship. See GAO, *Medicaid: States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*, [GAO-07-889](#) (Washington, D.C.: June 28, 2007).

^cWhile states' plans for reporting these immigration-related data elements were not always clear from the available documentation, Virginia noted that they plan to report these data elements in 2020. In contrast, Washington officials indicated that the state does not plan to report one of these data elements, citing the cost associated with doing so.

^dWe have reported that the Medicaid Statistical Information System (MSIS) does not identify supplemental payments made to individual providers. See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017).

^eOver the years, we have raised concerns about states making large Medicaid supplemental payments, often to government providers, such as local government and state-operated hospitals and

other health care facilities. See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

Another factor affecting the ability of CMS and states to use T-MSIS data for oversight is that not all of the 49 states submitting T-MSIS data are submitting current data. According to CMS officials, before beginning to report T-MSIS data, each state stops reporting MSIS data. At that point, there is a temporary gap in the state's reporting until it receives CMS's approval to begin reporting T-MSIS data. After a state gets CMS's approval, it must first submit the T-MSIS data that correspond to the date that it stopped submitting MSIS data; the data for previous months is known as "catch up" data. Once a state reports that data, it then shifts to reporting current T-MSIS data. According to CMS, as of November 2017, 42 of the 49 states reporting T-MSIS data were reporting current data; the remaining 7 states were still reporting catch up data for previous months.³⁶

Regarding the comparability of T-MSIS data across states, state officials we interviewed cited concerns that could affect their use of T-MSIS for oversight. Officials from most selected states cited the benefit that a national repository of T-MSIS data could provide by allowing them to compare their Medicaid program data—such as spending or utilization rates—to other states, which could potentially improve their oversight. However, concerns about comparability of the data make officials from most selected states hesitant to use the data for this purpose. In particular, officials from six of eight selected states, and other individuals we interviewed, are not confident that the decisions states made when converting their data to the T-MSIS format were consistent across states. An individual who worked with other states on T-MSIS reporting efforts noted that states may have made different decisions about what types of providers to include as part of the "all other" category of providers within T-MSIS. While one state he worked with included a range of provider types, such as licensed drug and alcohol counselors and non-emergency medical transportation providers, in the "all other" T-MSIS provider

³⁶Based on our sample of states, the amount of time needed to "catch up" and report current T-MSIS data can vary widely. For example, after stopping its MSIS submissions, Pennsylvania took roughly one year to report its first T-MSIS data and then about another 6 months to report current data, according to state officials. In contrast, North Carolina took more than 3 years to start reporting T-MSIS data, but only needed an additional 3 months to catch up and be able to report current data, according to state officials. Despite the varied experiences of selected states, CMS officials told us that they have found most states report current data within a few months of first reporting T-MSIS data.

category, other states may have made different decisions.³⁷ Some state officials and individuals working with states noted that states' different decisions may complicate their ability to use the data for cross-state comparisons. Further, officials from some of the selected states noted that they were not familiar with the quality of other states' T-MSIS data.

CMS has begun to take steps to address the quality of the T-MSIS data; however, its efforts are still evolving. For example, in May 2017, CMS identified 12 data quality priority areas for states to focus on for improving the accuracy and consistency of T-MSIS data, including accurately categorizing beneficiaries into T-MSIS eligibility groups and ensuring consistency related to MCO reporting. CMS has worked to identify existing or develop new guidance for each of these priority areas, and to compile the guidance in a central location for states' reference. As of August 2017, CMS officials said they compiled guidance for 11 of the 12 areas, and intended to continue work with states on these priorities.

In addition, CMS has not created a mechanism to disseminate information about states' data limitations or states' efforts to improve and use the data, which also affects their utility for oversight. Officials from four of the eight selected states said that learning more about other states' T-MSIS data could help allay their concerns about comparability, and two of the four states said it could also help them address their own data quality issues. Additionally, officials from all eight selected states were interested in opportunities to learn more about other states' use of the data.

CMS officials acknowledged the benefits of a mechanism to disseminate information about states' data limitations more broadly, and to facilitate information sharing among states. CMS officials told us that they plan to launch a Learning Collaborative with states to facilitate feedback and collaboration. This effort could address a range of data-related topics, including data quality. CMS officials told us they were taking actions to put the Learning Collaborative in place, and may launch the collaborative in early 2018.

³⁷ CMS officials noted that states are required to use industry-standard classifications for each provider and on each claim or MCO encounter in addition to the provider type and specialty classifications. For example, separate codes exist for addiction psychiatrists and addiction counselors, as well as for various types of substance use disorder treatment facilities. These officials also noted that T-MSIS is intended to capture detailed, industry standard procedure codes to identify addiction counseling services rendered to patients regardless of provider classification.

The lack of an effort to facilitate information sharing is inconsistent with CMS's goals for T-MSIS and with federal internal control standards for using and communicating quality information to achieve objectives.³⁸ Absent such an effort, CMS is missing an opportunity to help states understand ways they could improve the quality of their T-MSIS data and facilitate states' use of the data for oversight. CMS is also missing an opportunity to expedite quality improvements that could result from states conducting their own independent analyses.

Although CMS has taken steps to begin using T-MSIS data, it has not yet fully articulated a plan for how and when it will use T-MSIS data for its own broader oversight efforts of state Medicaid programs. For example, according to CMS officials, the agency has begun to use T-MSIS data to generate Money Follow the Person reports, and has begun exploring additional uses of T-MSIS data to reduce states' reporting burden.³⁹ These preliminary efforts are consistent with one of CMS's stated goals for T-MSIS, which is to reduce states' reporting burden by relying on T-MSIS data in place of separate reports that states currently submit, and officials from six of eight selected states indicated that such an effort would reduce their reporting burden.

However, as of August 2017, CMS officials acknowledged that they had yet to outline how best to use T-MSIS data for program monitoring, oversight, and management, because they were still largely focused on working with the remaining states to begin reporting T-MSIS data, analyzing the quality and usability of the T-MSIS data, and preparing the data for research purposes. CMS's lack of a specific plan and time frames for using T-MSIS data is inconsistent with federal internal control standards related to using and communicating quality information to achieve objectives. Absent a specific plan and time frames, CMS's ability to use these data to oversee the program, including ensuring proper payments and beneficiaries' access to services, is limited.

³⁸See [GAO-14-704G](#).

³⁹The Money Follows the Person Rebalancing Demonstration Grant was established to support states' transition of eligible individuals who want to move from institutional settings, such as a nursing home, back to the community. CMS officials said they are exploring using T-MSIS data for Early and Periodic Screening, Diagnostic, and Treatment program reports and for quality measures.

Conclusions

As part of its efforts to address longstanding concerns about the data available to oversee the Medicaid program, CMS has taken important steps toward developing a reliable national repository for Medicaid data. T-MSIS has the potential to improve CMS's ability to identify improper payments, help ensure beneficiaries' access to services, and improve program transparency, among other benefits. By providing more standardized data on various aspects of Medicaid—such as spending or utilization rates—states could be better positioned to compare their programs to other states, thereby improving their ability to identify program inefficiencies or opportunities for improvement.

Implementing the T-MSIS initiative has been a significant undertaking. Over the past 6 years, CMS has worked closely with states and has reached a point where nearly all states are reporting T-MSIS data. While recognizing the progress that has been made, more work needs to be done before CMS or states can use these data for program oversight. It remains unclear when all states will report complete and comparable T-MSIS data, and how CMS and states will use them to improve oversight. In the interim, improper Medicaid payments continue to increase, reaching \$36.7 billion in fiscal year 2017. Further delays in T-MSIS's use limit CMS's ability to reverse that trend in the near term, underscoring the need for CMS to take additional steps to expedite the use of the data.

Recommendations for Executive Action

We are making the following two recommendations to CMS.

The Administrator of CMS, in partnership with the states, should take additional steps to expedite the use of T-MSIS data for program oversight. Such steps should include, but are not limited to, efforts to

- obtain complete information from all states on unreported T-MSIS data elements and their plans to report applicable data elements;
- identify and share information across states on known T-MSIS data limitations to improve data comparability; and
- implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an ongoing basis to improve the

completeness, comparability, and utility of T-MSIS data.
(Recommendation 1)

The Administrator of CMS should articulate a specific plan and associated time frames for using T-MSIS data for oversight. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its written comments, HHS concurred with our recommendations, and noted that strong Medicaid data can help the federal government and the states move toward better health outcomes and improve program integrity, performance, and financial management. With most states now reporting T-MSIS data, HHS highlighted efforts it has taken to improve the quality of T-MSIS data. For example, HHS developed a database on data quality findings, which could be used to identify solutions for common problems across states, and has begun to develop a data quality scorecard for T-MSIS users, which aggregates data quality findings in a user-friendly tool. Regarding taking steps to expedite the use of T-MSIS data for program oversight, HHS stated that it will (1) continue to work to obtain complete T-MSIS information from all states; (2) take additional steps to share information across states on T-MSIS data limitations; and (3) implement ways for states to collaborate regarding T-MSIS. HHS also noted that it is in the process of developing a plan for using T-MSIS data for oversight. HHS emphasized that it is dependent on states—and their available staffing and resources—to address data quality and reporting issues. HHS also provided technical comments, which we incorporated as appropriate. HHS's comments are reprinted in appendix I.

As agreed with your office, 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 HHS, 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 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 can 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

List of Requesters

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Thomas R. Carper
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
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

NOV 08 2017

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: Further Action Needed to Expedite Use of National Data for Program Oversight*" (GAO-18-70).

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

Sincerely,



Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: FURTHER ACTION NEEDED TO EXPEDITE USE OF NATIONAL DATA FOR PROGRAM OVERSIGHT (GAO-18-70)

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. HHS takes seriously its responsibility to collect and analyze Medicaid and Children's Health Insurance Program (CHIP) data to enhance program management and oversight.

Improving Medicaid and CHIP data and systems is a high priority for HHS. Through strong data and systems, HHS and states can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. 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 (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.

HHS is working to transition all states to T-MSIS and has made significant progress. As of October 17, 2017, 48 states have begun submitting T-MSIS data. These 48 entities represent 96 percent of the Medicaid and CHIP population. HHS continues to work with the remaining states to help them submit data and expects all states to report T-MSIS data by 2018.

With a majority of states submitting T-MSIS data, HHS has begun to develop tools for T-MSIS users, as well as work with states to improve the quality of data submitted. For example, HHS is developing a data quality scorecard for users, which aggregates data quality findings in a user-friendly tool. In addition, HHS has developed a data quality database that houses post-production data quality findings to help develop solutions for common problems seen across multiple states. These efforts will help states report complete and comparable T-MSIS data which HHS plans to use for program oversight efforts.

In addition, HHS currently has controls in place to protect against potentially improper Medicaid payments using T-MSIS and other data sets. For example, financial and expenditure data derived from the Medicaid Budget and Expenditure System is used to perform financial reconciliations as well as other oversight activities. HHS also conducts numerous Medicaid program integrity efforts such as provider audits, State Program Integrity Reviews, and publishes guidance to states on Medicaid fraud prevention, provider screening and enrollment initiatives, and state-specific program integrity review reports.

These efforts, along with more robust, timely, and accurate data via T-MSIS will strengthen program monitoring, policy implementation, and oversight of Medicaid and CHIP programs. It will also enhance HHS' and states' ability to identify potential fraud, waste, and abuse and improve program efficiency. 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.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: FURTHER ACTION NEEDED TO EXPEDITE USE OF NATIONAL DATA FOR PROGRAM OVERSIGHT (GAO-18-70)

GAO's recommendations and HHS's responses are below.

GAO Recommendation

The Administrator of CMS, in partnership with the states, should take additional steps to expedite use of T-MSIS data for program oversight. Such steps should include, but are not limited to:

- Obtain complete information from all states on unreported T-MSIS data elements and their plans to report applicable data elements;
- Identify and share information across states on known T-MSIS data limitations to improve data comparability; and
- Implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T-MSIS data.

HHS Response

HHS concurs with this recommendation. HHS has worked to obtain complete information from all states on unreported T-MSIS data, and will continue to do so. However, HHS is dependent on states and their associated staffing and resources necessary to address data quality issues and data reportability. HHS will continue to share information across states on known T-MSIS data limitations and will implement ways in which states can collaborate on an ongoing basis regarding T-MSIS implementation.

GAO Recommendation

The Administrator of CMS should articulate a specific plan and associated time frames for using T-MSIS data for oversight.

HHS Response

HHS concurs with this recommendation. HHS is in the process of developing a plan for using T-MSIS data for oversight across the agency.

Appendix II: 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, individuals making key contributions to this report include Susan Anthony (Assistant Director), Manuel Buentello (Analyst-in-Charge), Anna Bonelli, and Robin Burke. Also contributing were Muriel Brown, Drew Long, and Jennifer Rudisill.

Appendix III: Accessible Data

Agency Comment Letter

Text of Appendix I: 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 Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight" (GAO-18-70).

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

Sincerely,

Barbara Pisaro Clark

Acting Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: FURTHER ACTION NEEDED TO EXPEDITE USE OF NATIONAL DATA FOR PROGRAM OVERSIGHT (GAO-18-70)

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Improving Medicaid and CHIP data and systems is a high priority for HHS. Through strong data and systems, HHS and states can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. 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 (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.

HHS is working to transition all states to T-MSIS and has made significant progress. As of October 17, 2017, 48 states have begun submitting T-MSIS data. These 48 entities represent 96 percent of the Medicaid and CHIP population. HHS continues to work with the remaining states to help them submit data and expects all states to report T-MSIS data by 2018.

With a majority of states submitting T-MSIS data, HHS has begun to develop tools for T-MSIS users, as well as work with states to improve the quality of data submitted. For example, HHS is developing a data quality scorecard for users, which aggregates data quality findings in a user-friendly tool. In addition, HHS has developed a data quality database that houses post-production data quality findings to help develop solutions for common problems seen across multiple states. These efforts will help states report complete and comparable T-MSIS data which HHS plans to use for program oversight efforts.

In addition, HHS currently has controls in place to protect against potentially improper Medicaid payments using T-MSIS and other data sets. For example, financial and expenditure data derived from the Medicaid Budget and Expenditure System is used to perform financial reconciliations as well as other oversight activities. HHS also conducts numerous Medicaid program integrity efforts such as provider audits, State Program Integrity Reviews, and publishes guidance to states on Medicaid fraud prevention, provider screening and enrollment initiatives, and state-specific program integrity review reports.

These efforts, along with more robust, timely, and accurate data via T-MSIS will strengthen program monitoring, policy implementation, and oversight of Medicaid and CHIP programs. It will also enhance HHS' and states' ability to identify potential fraud, waste, and abuse and improve program efficiency. 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.

Page 3

GAO's recommendations and HHS's responses are below.

GAO Recommendation

The Administrator of CMS, in partnership with the states, should take additional steps to expedite use of T-MSIS data for program oversight. Such steps should include, but are not limited to:

- Obtain complete information from all states on unreported T-MSIS data elements and their plans to report applicable data elements;
- Identify and share information across states on known T-MSIS data limitations to improve data comparability; and
- Implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T-MSIS data.

HHS Response

HHS concurs with this recommendation. HHS has worked to obtain complete information from all states on unreported T-MSIS data, and will continue to do so. However, HHS is dependent on states and their associated staffing and resources necessary to address data quality issues and data reportability. HHS will continue to share information across states on known T-MSIS data limitations and will implement ways in which states can collaborate on an ongoing basis regarding T-MSIS implementation.

GAO Recommendation

The Administrator of CMS should articulate a specific plan and associated time frames for using T-MSIS data for oversight.

HHS Response

HHS concurs with this recommendation. HHS is in the process of developing a plan for using T- MSIS data for oversight across the agency.

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