

# Office of Inspector General

## Data Brief

March 2021, OEI-02-19-00180



## Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate

### Key Takeaways

- Most States did not provide complete or accurate data in the national data system—T-MSIS—on Medicaid managed care payments to providers, and two States failed to provide any data for January 2020.
- CMS and States need complete and accurate payment data to effectively monitor and administer Medicaid managed care, the primary delivery system of the Medicaid program.
- The need for complete and accurate payment data is more important than ever, given the unprecedented stress the COVID-19 pandemic has placed on the Medicaid program.

### Why OIG Did This Review

Effective oversight of Medicaid requires a national system with complete and accurate data. The Centers for Medicare & Medicaid (CMS) established the Transformed Medicaid Statistical Information System (T-MSIS) for this purpose. Payment data are a critical component of T-MSIS. These data include the amounts paid, billed, and allowed for every service provided to Medicaid enrollees, including those services provided through managed care.

Managed care has become the primary delivery system for Medicaid. Each managed care plan provides the State with data about what the plan paid providers for their encounters with Medicaid enrollees. The State is then required to submit these data to T-MSIS. The Office of Inspector General (OIG) and others have consistently identified deficiencies in the quality of T-MSIS data, including particular concerns with the quality of data for managed care.

CMS and others rely on T-MSIS data to provide oversight; to identify trends; and to detect fraud, waste, and abuse. States use payment data to set the capitation rates paid to managed care plans for each enrollee and to monitor the services provided by the plans.

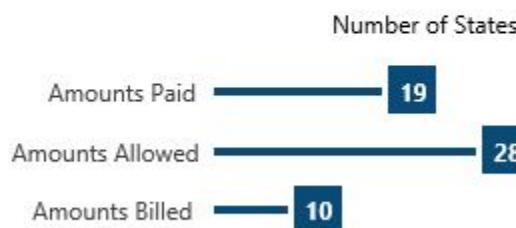
### How OIG Did This Review

We analyzed the payment data from the encounter claims in T-MSIS for January 2020 for the largest managed care plan in each of the 39 States that provide comprehensive, risk-based managed care.

### What OIG Found

Most States did not provide complete or accurate payment data in T-MSIS on managed care payments to providers; two States failed to provide any data for January 2020. Notably, about half of States did not provide complete or accurate information about the amounts that managed care plans pay to providers for services—the **amount paid**. Almost three-quarters of the States provided incomplete or inaccurate information about the maximum amounts that managed care plans allow for services—the **amount allowed**. Over a quarter of the States provided incomplete or inaccurate information about the amounts that providers bill managed care plans for services—the **amount billed**.

**Many of the 39 States had incomplete or inaccurate information for the amounts paid, allowed, and billed.**



With the rise in Medicaid enrollment and changes in utilization, the COVID-19 pandemic has demonstrated how essential it is to have complete and accurate national Medicaid data. T-MSIS data are more important than ever to

ensure proper oversight and that Medicaid funds are spent appropriately. These data can be used to identify emerging trends as well as to inform public health efforts.

## **What OIG Recommends**

We recommend that CMS review States' managed care payment data in T-MSIS and ensure that States have corrective action plans to improve data completeness and quality, as appropriate. Further, CMS should make public its reviews of States' managed care data. Finally, CMS should clarify and expand its initiative on payment data. CMS did not concur with any of our three recommendations. CMS noted that it has already set priority areas for improving the reporting of T-MSIS data and it will continue to assess how to further expand data quality improvement efforts. We continue to press CMS to take the recommended actions to improve the managed care payment data in T-MSIS so that these data can be used to effectively monitor and oversee the Medicaid program.



## Primer: T-MSIS and Medicaid Managed Care Provider Payment Data

### T-MSIS

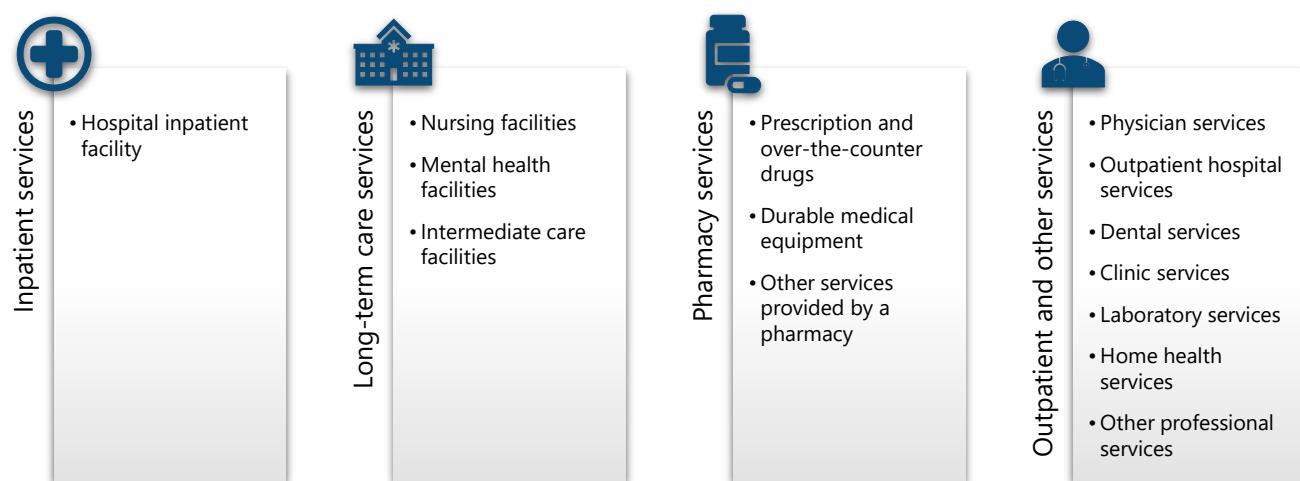
- T-MSIS is a national data system that contains data from Medicaid managed care and Medicaid fee-for-service for all 50 States and the District of Columbia.
- **Managed care data** in T-MSIS can be used to provide oversight of services and payments in Medicaid managed care. Medicaid managed care is the primary delivery system for Medicaid services, covering 70 percent of the Medicaid population. In total, 39 States provide comprehensive, risk-based managed care.
- Managed care plans submit an **encounter claim** (claim) for each enrollee encounter or visit to a provider. Each claim includes information about the individual services provided during a visit. States are required to validate encounter claims for accuracy before submitting the claims to T-MSIS.

### Provider Payment Data

- Each encounter claim includes the total amounts billed, allowed, and paid for the encounter or visit. Some claims also include the amounts billed, allowed, and paid for each individual service. These data do not include the capitated payments that the State pays to the managed care plan.



- Encounter claims are organized into four files by type of service:



# RESULTS

## Most States did not provide complete or accurate data in T-MSIS on Medicaid managed care payments to providers; two States failed to provide any data

For 31 of the 39 States with managed care, the State did not provide complete or accurate data in T-MSIS on payments to providers for the State's largest plan.<sup>1</sup> These data come from encounter claims for January 2020 and include the amounts paid, allowed, or billed for each encounter or visit with a provider.<sup>2</sup> We considered a State to have incomplete or inaccurate data if it had inappropriate zeros, missing data, or negative amounts.

Accurate payment data are critical for monitoring and administering the Medicaid program. States use payment data to set the capitation rates that they pay to managed care plans for each enrollee and to monitor the services provided by the plans.<sup>3</sup> CMS and other stakeholders rely on the payment data in T-MSIS to manage and oversee managed care plans, as well as to monitor plan payments to providers to detect fraud, waste, and abuse. This information is also essential to CMS and others to compare costs for certain services and populations and to compare costs across States.

A national system with complete and accurate payment data is particularly important given the rise in Medicaid enrollment and changes in utilization during the COVID-19 pandemic. Protecting the fiscal integrity of Medicaid during the pandemic has taken on a new urgency. CMS and others can use these data to administer the program and conduct oversight, including to identify emerging fraud schemes nationwide and to monitor payments to providers.

Many States had incomplete or inaccurate information for two or more of the following types of payment data: amounts paid, amounts allowed, and amounts billed. See text box.

Even more concerning, 2 of the 31 States failed to submit any claims—meaning any payment data or record of services provided—from their largest plans. One of these States, Colorado, submitted no claims for its

**17 States had incomplete or inaccurate information for multiple types of payment data.**

**9 States had incomplete or inaccurate information for all **three** types of payment data**

**8 States had incomplete or inaccurate information for **two** types of payment data**

largest plan for January 2020. The other State, North Dakota, submitted no claims in T-MSIS for its only comprehensive, risk-based managed care plan for January 2020 and all of 2019. The lack of claims in T-MSIS makes it impossible for CMS and others to effectively evaluate the Medicaid managed care program in these two States.

## About half of States did not provide complete or accurate information about the amounts paid for services

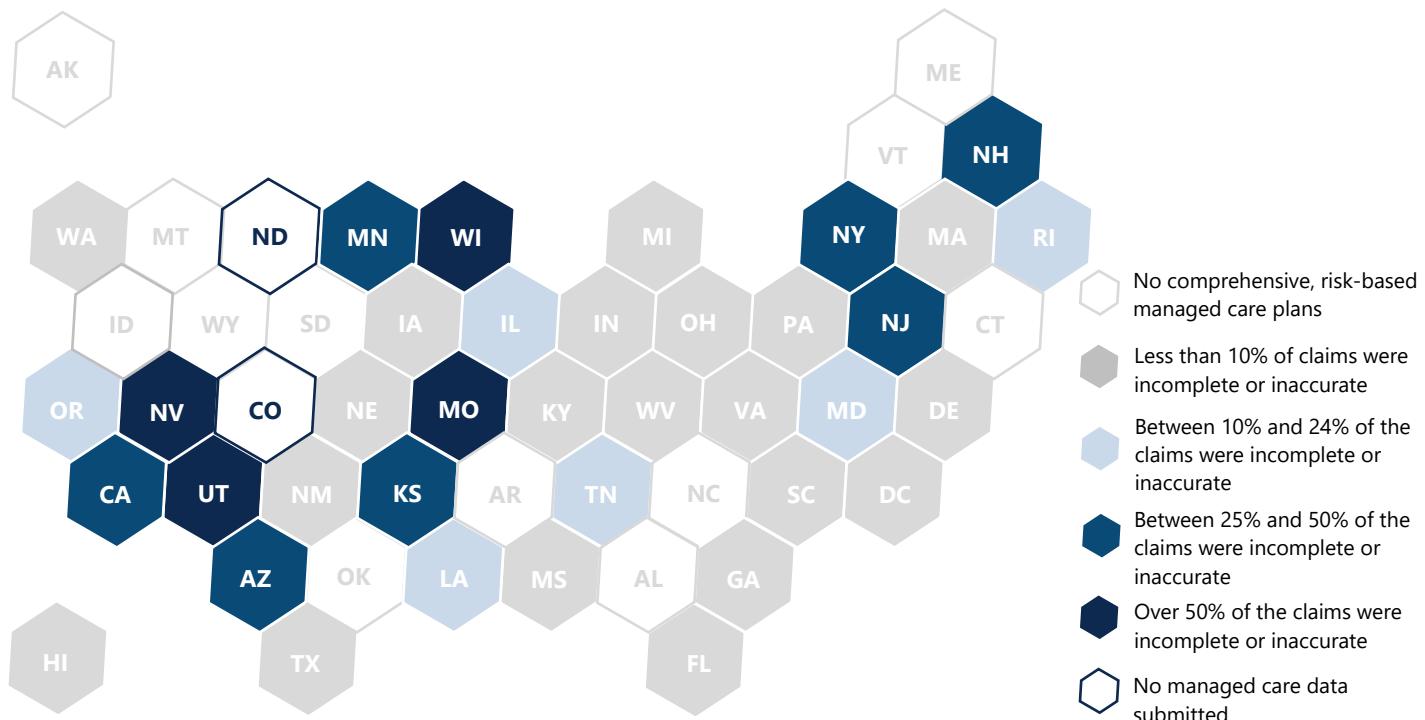
Of the 39 States with managed care, 19 States had incomplete or inaccurate information for the total amounts paid for services for their largest plan.<sup>4</sup> This includes the total amount that managed care plans pay for Medicaid services for an enrollee for an encounter such as a hospital stay, or for all services provided during an office visit.

Having complete and accurate data about the amounts that Medicaid managed care plans pay for services for enrollees is critical. Such data permit CMS and others to detect irregular billing practices and overpayments to providers that could indicate fraud or abuse of the program. For example, the amount paid can be used to identify providers who receive unusually high or low payments.

In total, the 19 States had incomplete or inaccurate data for the amount paid, for a median of 40 percent of their claims.<sup>5</sup> Four States—Missouri, Nevada, Utah, and Wisconsin—had incomplete or inaccurate data for over half of their claims. Two States did not submit any claims, including any data on paid amounts. See Exhibit 1 and Appendix B.

Most commonly, States had inappropriate zeros for the amount paid, which may inaccurately indicate that plans did not pay anything for the service. In other cases, States did not have any information for the amounts paid (i.e., the data were missing). CMS states that an unreasonable percentage of zeros or missing amounts paid may indicate a data quality issue.<sup>6</sup> In some circumstances, States may have submitted zeros or did not provide any data for the amount paid when a plan pays its providers through an arrangement other than on a fee-for-service basis, such as sub-capitated or value-based arrangements.<sup>7</sup> CMS currently does not have specific guidance about how States should submit payment data in T-MSIS for these arrangements.

## Exhibit 1: States With Incomplete or Inaccurate Data for Amounts Paid



States were more likely to have incomplete or inaccurate data for certain types of services than for others. Notably, 23 States had incomplete or inaccurate data for the amounts paid for the category of "outpatient and other services," which includes visits with primary care providers and specialists. Many States also had incomplete or inaccurate data for the amounts paid for hospital inpatient services. See text box.

In total, 25 percent of claims for outpatient and other services were incomplete or inaccurate, compared to 13 percent of claims for hospital inpatient services,

**States were more likely to have incomplete or inaccurate information for the amounts paid for certain types of services.**

- **23** States had incomplete or inaccurate data for **outpatient and other** services
- **21** States had incomplete or inaccurate data for hospital **inpatient** services
- **13** States had incomplete or inaccurate data for **long-term care** services
- **10** States had incomplete or inaccurate data for **pharmacy** services

10 percent of claims for long-term care services, and 6 percent of claims for pharmacy services.

In addition, many States had incomplete or inaccurate data for the amounts paid for individual services provided during an encounter.<sup>8</sup> In addition to providing the total amounts paid for each encounter or visit, States commonly provide the amount paid for each individual service provided during an encounter or visit. Twenty-eight States had incomplete or inaccurate data for the amounts paid for these individual services. Many of these States had incomplete or inaccurate data for physician, outpatient, and laboratory services. See Appendix A.

Further, a number of States provided inconsistent data for the individual services and the total encounter. For nine States, 10 percent or more of their claims had amounts paid for individual services that did not sum to the total amount paid for that encounter. When these amounts do not match, it indicates that there are inaccuracies or missing information in the amounts paid for at least one of the individual services or for the total amount paid for that encounter.

#### **Information about the date of payment was also often incomplete**

Seven States had incomplete information about the date when the managed care plan paid the provider, presenting additional challenges for oversight. The paid date is important because it may be used to categorize claim payments into the appropriate fiscal quarter or year.

## **Almost three-quarters of the States provided incomplete or inaccurate information about the amounts allowed for services**

Of the 39 States with managed care, 28 States had incomplete or inaccurate information for the amounts allowed for their largest plan. The amount allowed is the maximum payment amount that a managed care plan allows for a service.

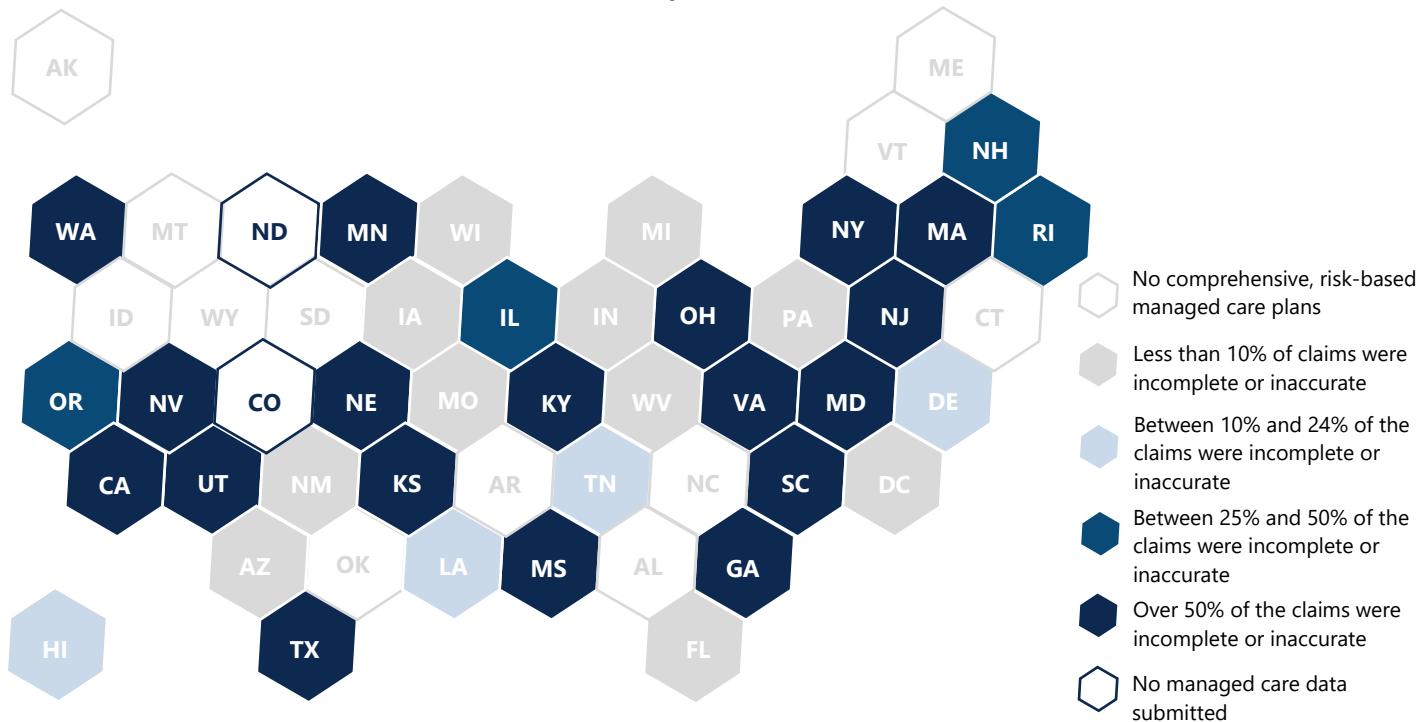
Having complete and accurate data about the amounts allowed is critical for effective oversight of the Medicaid program. Such data permit CMS and others to determine whether the Medicaid managed care plan paid more than the amount allowed for a service, which could indicate potential overpayments. Overpayments can increase the cost of the Medicaid program and can also affect enrollees who may be responsible for certain out-of-pocket costs, which are a portion of the cost of each service. In addition, CMS and others are able to use the amounts allowed to compare negotiated rates for services across different plans and different States and to analyze whether certain rates affect access to care.

Many States had incomplete or inaccurate data for the allowed amount for almost all their claims. See Exhibit 3 and Appendix B. Notably, 17 States had incomplete or inaccurate data for over 90 percent of their claims. CMS staff note that when States use a certain standardized form adopted by CMS to submit claims to T-MSIS, they are

unable to include the allowed amount because there is no field for it in the standardized form. This may explain why the allowed amount is often missing on the claims that States submit to T-MSIS. In addition, CMS has not yet provided guidance to States on how to submit this amount to T-MSIS.

Most commonly, States had inappropriate zeros for the amount allowed; in other cases, they did not have any information for the amounts allowed (i.e., the data were missing).

### Exhibit 3: States With Incomplete or Inaccurate Data for Amounts Allowed



Source: OIG analysis of T-MSIS data, 2020.

Note: This analysis is based on the largest managed care plan in each State and includes claims processed in January 2020.

States commonly had incomplete or inaccurate data for the amount allowed for multiple types of services, including outpatient and other services and inpatient and long-term care services. See text box.

In total, 72 percent of claims for long-term care services had incomplete or inaccurate amounts allowed, compared to 64 percent of claims for outpatient and other services and 60 percent of claims for hospital inpatient services.

In addition, many States had incomplete or inaccurate data for the amounts allowed for individual services provided during an encounter.<sup>9</sup> Twenty-nine States had incomplete or inaccurate data for the amount allowed for these individual services.

Further, 10 States had an amount paid for an individual service that was greater than the amount the managed care plan allowed for that service. This was true for at least 10 percent of those States' claims. An amount paid to a provider that exceeds the amount allowed could indicate the managed care plan made an overpayment to the provider.

## Over a quarter of the States provided incomplete or inaccurate information about the amounts billed for services

Of the 39 States with managed care, 10 States had incomplete or inaccurate information for the total amounts billed for services for their largest plan. Having complete and accurate data about the amounts billed is important because these amounts can be used by CMS and others to analyze providers' billing practices. They can use these amounts to identify how much providers are billing Medicaid managed care plans for services and track providers that are outliers.

The 10 States had incomplete or inaccurate data for the amounts billed, for a median of 33 percent of their claims. Three States had incomplete or inaccurate data for over half of their claims. See Exhibit 5 and Appendix B.

Most commonly, States had inappropriate zeros for the amount billed; in other cases, they did not have any information for the amounts billed (i.e., the data were missing).<sup>10</sup>

**States commonly had incomplete or inaccurate information for the amounts allowed for multiple types of services.**



**28** States had incomplete or inaccurate data for **outpatient and other** services

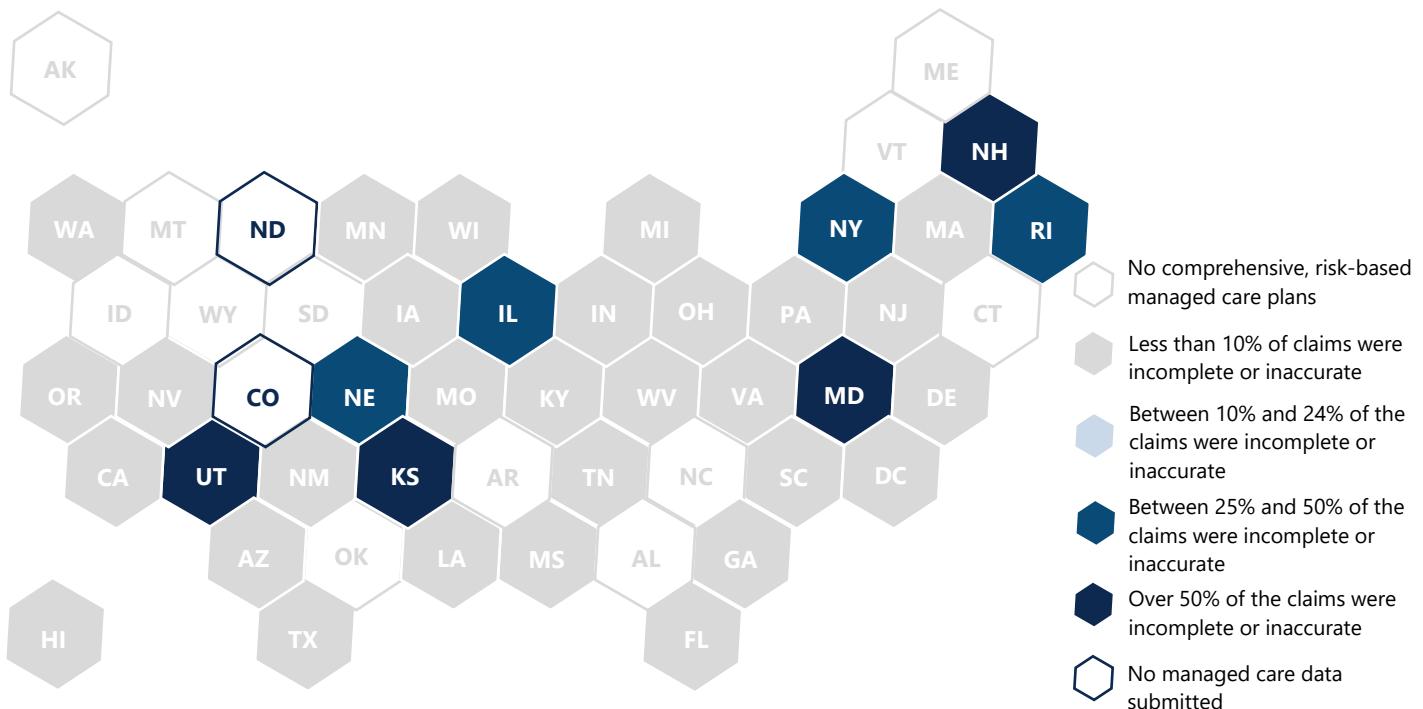


**28** States had incomplete or inaccurate data for hospital **inpatient** services



**24** States had incomplete or inaccurate data for **long-term care** services

## Exhibit 5: States With Incomplete or Inaccurate Data for Amounts Billed



Source: OIG analysis of T-MSIS data, 2020.

Note: This analysis is based on the largest managed care plan in each State and includes claims processed in January 2020.

Fewer than one-third of States had incomplete or inaccurate data for the amounts billed for each type of service. Ten States had incomplete or inaccurate data for outpatient and other services. See text box.

In total, 7 percent of claims for outpatient and other services were incomplete or inaccurate, compared to 6 percent of claims for pharmacy services, 3 percent of claims for long-term care services, and 2 percent of claims for hospital inpatient services.

In addition, eight States had incomplete or inaccurate data for the amount billed by providers for individual services provided during an encounter.<sup>11</sup>

**Fewer than one-third of States had incomplete or inaccurate information for the amounts billed for each type of service.**

- 10 States had incomplete or inaccurate data for **outpatient and other** services
- 7 States had incomplete or inaccurate data for hospital **inpatient** services
- 7 States had incomplete or inaccurate data for **long-term care** services
- 6 States had incomplete or inaccurate data for **pharmacy** services

# RECOMMENDATIONS

Effective oversight requires a national system with complete and accurate payment data, including data from plans that provide managed care. CMS and others use the national system—T-MSIS—to oversee and administer the Medicaid program, which covers 70.6 million enrollees and has \$613.5 billion in expenditures.<sup>12</sup> In addition, States use payment data to set the capitation rates that they pay to managed care plans for each enrollee and to monitor the services provided by the plans.

CMS has made improving data quality in T-MSIS a priority. It is currently focused on improving a number of data elements, including the Medicaid managed care payment data for amount paid and amount billed in T-MSIS.<sup>13</sup> Notably, CMS conducts periodic checks of T-MSIS data for quality issues, provides guidance on the submission of the data in various documents, and works with the States one-on-one to address concerns related to the priority areas, which include payment data. In addition, it provides certain T-MSIS data to the public for research purposes and plans to release more recent data as the data become more complete.

Despite these actions, CMS needs to strengthen its efforts to improve the accuracy and completeness of managed care payment data in T-MSIS. Our findings show that some States are not submitting data to T-MSIS for their largest managed care plans, and when States are submitting data, the payment data are often incomplete or inaccurate. These deficiencies limit the usability of Medicaid T-MSIS data and hinder oversight and accountability of Medicaid managed care.

These findings echo longstanding issues highlighted in other studies that have consistently identified deficiencies in the quality of T-MSIS data.<sup>14</sup> Most recently, OIG found that States did not always submit complete Medicaid data needed for oversight, such as provider identifiers and diagnosis codes for opioid prescriptions.<sup>15</sup> In addition, the Government Accountability Office (GAO) reviewed CMS's assessment of its progress on the top priority areas and found that while some data has improved, not all data met the standards set in the priority areas, including the data for managed care.<sup>16</sup>

Having complete and accurate Medicaid data are especially important given the COVID-19 pandemic. As Medicaid enrollment has increased and utilization has changed, it is more important than ever that we are able to track Medicaid managed care payments for services and that we monitor utilization to ensure that enrollees are receiving necessary care. Also, these data can be used to detect potential fraud schemes that may have arisen during the pandemic and to inform public health efforts.

We recommend that CMS:

## **Review States' managed care payment data in T-MSIS and ensure that States have corrective action plans to improve data completeness and quality, as appropriate**

CMS should accelerate and strengthen its efforts to improve the completeness and accuracy of the managed care payment data in T-MSIS. In addition to accelerating its current efforts to improve T-MSIS data, CMS should also expand its efforts by conducting reviews of T-MSIS payment data by each State's managed care plans.

Analyses at the plan level could reveal underlying issues in the data and can provide valuable information to CMS and others to help resolve issues and provide better oversight.<sup>17</sup> CMS should share its results with the States and provide samples of potentially problematic claims related to payment data so that States can better identify and address underlying issues in a timely manner.

CMS should also use its authority, as appropriate, to develop corrective action plans or to defer or disallow certain Federal funding if States are not submitting complete and accurate managed care data.<sup>18</sup> These actions would prompt States and plans to improve the quality of their data in T-MSIS. In particular, CMS should work with the two States that failed to submit any claims data—not just payment data—for their largest plans.

## **Make public its reviews of States' managed care payment data**

CMS should publicly report the results of its reviews of the managed care data in T-MSIS. These public reports should include results summarizing the extent to which the payment data are complete and accurate for each individual managed care plan. CMS should build off its T-MSIS Analytic Files Data Quality State snapshots to create a version that is specific to managed care and provides findings on data quality at the plan level.<sup>19</sup> Making these reviews public would hold States and managed care plans more accountable for submitting complete and accurate payment data at the plan level. It would also make researchers and other stakeholders aware of problems with incomplete or inaccurate data in T-MSIS for certain managed care plans.

## **Clarify and expand its initiative on payment data**

CMS should clarify and emphasize the importance of reporting complete and accurate payment data for all managed care plans. As part of its efforts, CMS should clarify its expectations for submitting the amount paid for sub-capitated or value-based arrangements. Plans that have these arrangements with their providers may be submitting an unreasonable percentage of zeros or missing amounts paid. Not

having information about payments made to providers under these arrangements impedes the oversight efforts of CMS and others.

CMS's current initiative on improving the quality of payment data includes measures on the completeness and accuracy of the amount paid and the amount billed.<sup>20</sup> CMS should expand its current initiative on payment data by measuring the completeness and accuracy of the amount allowed and holding States accountable for providing this information. The amount allowed is a required data field for T-MSIS, but some standardized claim submission forms do not have a field for that amount. Almost three-quarters of the States have incomplete or inaccurate data on the amount allowed. Incorporating the amount allowed would prompt States to improve the quality of these data. CMS should also provide a solution or alternative option for States that are having difficulty submitting the allowed amount.

CMS should also further emphasize to States the importance of having complete and accurate payment data in T-MSIS. CMS should use the results of this report and its own analysis from its data quality initiative to further communicate to States about how to improve their payment data and to hold States accountable for the quality of the data they submit to T-MSIS.

# AGENCY COMMENTS AND OIG RESPONSE

CMS did not concur with any of our three recommendations. CMS stated that having access to robust data strengthens program monitoring. It noted that it has already set priority areas for improving the reporting of T-MSIS data and it will continue to assess how to further expand data quality improvement efforts.

Our findings demonstrate that further action focused on the quality of managed care payment data is needed. Managed care is now the primary delivery system for Medicaid. With over two-thirds of beneficiaries receiving managed care, CMS must hold States accountable for the quality of their managed care payment data and raise the bar, where needed. In addition, with the onset of the pandemic, T-MSIS data are more important than ever to ensure proper oversight and to ensure we can track Medicaid managed care payments for services.

We continue to press CMS to take the recommended actions to improve the managed care payment data in T-MSIS so that these data can be used to effectively monitor and oversee the Medicaid program. We acknowledge that these improvements may take some time to address, given the increased demands that States face due to the pandemic. We will follow up with CMS, as appropriate, to implement any outstanding recommendations.

CMS did not concur with our first recommendation that it review States' managed care payment data in T-MSIS and ensure that States have corrective action plans to improve data completeness and quality.

CMS stated that it identifies Top Priority Items (TPI) to help States focus on improving the accuracy and completeness of T-MSIS data and has recently expanded them to 32. It also noted that it has already streamlined State Plans of Action—which serve as corrective action plans—to address data quality issues. CMS also reported that States were made aware of enforcement actions and that CMS may reduce enhanced Federal Financial Participation for operational costs of systems unable to produce timely, accurate, and complete T-MSIS data and that all States had met the reporting threshold as of March 2020. In addition, CMS noted that the two States that were not submitting managed care data are now able to do so. Finally, while CMS commented that OIG did not determine whether missing data originated from the managed care plans or from the States, it noted that States bear the responsibility for ensuring the quality of data submitted to T-MSIS and that it has provided States with tools and resources for identifying and resolving data quality issues.

While we appreciate CMS's efforts, we maintain that CMS should strengthen its efforts and conduct reviews of T-MSIS payment data by each State's managed care plans. We maintain that evaluating payment data for each managed care plan will allow CMS to pinpoint data quality issues and solutions that may not be apparent when analyzing data at the State level. We further note that reviewing the payment data at

the plan level is critical to improving these data, regardless of where the quality issues may have originated. This type of analysis can help CMS and States sort out and better understand why the data may be inaccurate or incomplete in T-MSIS. This approach also complements CMS's current efforts in that it can uncover underlying problems that go beyond the particular data fields that are the focus of the TPIs. Further, the findings of this report—that 31 States did not provide complete or accurate payment data in T-MSIS—demonstrate that CMS needs to do more, including ensuring that States have corrective action plans to improve these data.

CMS did not concur with our second recommendation to make public its reviews of States' managed care payment data.

CMS stated that it already publicly reports the results of its reviews through its T-MSIS Analytic Files (TAF), which are publicly available data files, and the Data Quality (DQ) Atlas, which is a web-based tool that helps users explore the quality and usability of the TAFs. While we appreciate CMS's efforts to provide these data to the public, we note that neither the TAFs nor the DQ Atlas include results on managed care payment data. We agree with CMS that publishing information on Medicaid data quality can incentivize improvements. We reiterate that making public its reviews of the extent to which the payment data are complete and accurate for each managed care plan is important; it will similarly provide a strong incentive for plans to improve their data submissions.

CMS did not concur with our third recommendation to clarify and expand its initiative on payment data.

CMS stated that while it appreciates OIG's recommendation about expanding the focus of its initiative to include the amount allowed and holding States accountable for providing this information, it is important to note that data quality efforts must be balanced with States' increasing workloads, which has been made more difficult due to the pandemic. CMS further noted that although the allowed amount for managed care payment data is required, there are barriers to obtaining these data because plans may be reluctant to submit the data and may experience technical difficulties when submitting. In addition, CMS stated that it recognizes that guidance is needed to clarify how States should submit payment data for managed care plans that pay providers through payment arrangements other than on a fee-for-service basis and will continue existing plans to provide States with the necessary guidance.

Based on our findings, we maintain that CMS can help States improve their submissions of managed care payment data by expanding its initiative to include the allowed amount. We appreciate CMS's willingness to consider these changes in future updates to its TPIs and provide additional support to States to meet this new requirement. CMS should provide a solution or alternative option for States that are having difficulties submitting the allowed amount. We also note that providing guidance for submitting payment data for payment arrangements that are not on a fee-for-service basis would help improve the managed care data.

For the full text of CMS's comments, see Appendix C.

# METHODOLOGY

This study was based on an analysis of managed care payment data in T-MSIS. We reviewed the claims for the largest comprehensive, risk-based managed care plan in each of 39 States. We analyzed claims processed in January 2020. We conducted our review in August 2020 to allow time for those claims to be submitted to T-MSIS.

## Identification of the managed care plans

We determined that 39 States had at least one comprehensive, risk-based managed care plan.<sup>21</sup> Comprehensive managed care plans provide a comprehensive range of services that include acute care, primary care, specialty care, and other services. To identify the largest such plan in each of these States, we reviewed Medicaid enrollment data published on each State's website.<sup>22</sup>

We identified each of these plans in T-MSIS. Using the enrollment data for each plan from CMS's Integrated Data Repository, we determined the plan identification numbers associated with each plan.<sup>23</sup> A plan may have multiple plan identifiers that represent, for example, regional locations or specific enrollee populations. We confirmed both the plan names and their plan identifiers with each State.

## Analysis of T-MSIS payment data

We analyzed the T-MSIS data from CMS's Integrated Data Repository to determine the extent to which each State provided complete or accurate payment data for its largest plan for claims processed in January 2020.<sup>24</sup>

We focused our analysis on key payment data.<sup>25</sup> For each State's largest plan, we determined the completeness and accuracy of the following payment fields: paid amount, allowed amount, and billed amount.

For each type of payment data, we determined the number of States that had incomplete or inaccurate data.<sup>26</sup> We considered a State to have incomplete or inaccurate data if at least 10 percent of the State's claims had inappropriate zeros, no information, or negative amounts in the payment field.<sup>27</sup>

Next, for each type of payment data, we determined the number of States that had incomplete or inaccurate data by type of service (i.e., inpatient, long-term care, pharmacy, and "outpatient and other services"). We then determined the percentage of claims with incomplete or inaccurate data in each of the service files for all the States.

In addition to the two analyses described above that we conducted for each encounter, we analyzed the individual services provided during each encounter or

visit. For each type of payment data, we determined the number of States that had incomplete or inaccurate data.

We conducted additional analyses for the paid amount. We determined the number of States and the percentage of claims across all States that had incomplete or inaccurate data for physician, outpatient, and laboratory services. We also determined the number of States with claims in which the sum of the amounts paid for individual services during an encounter did not equal the total amount paid for that encounter—we considered this to be an issue if it occurred in at least 10 percent of a State's claims.

Further, we determined the number of States that had incomplete information about the date when the managed care plan paid the provider. We considered a State to have such incomplete information if at least 10 percent of the State's claims had no information in the date field.

We conducted an additional analysis for the amount allowed. We determined the number of States with claims in which the amount paid for an individual service was greater than the amount the managed care plan allowed for that service. We considered a State to have such claims if at least 10 percent of the State's claims had a paid amount greater than the allowed amount.

## Limitations

We based our analysis on the data in T-MSIS. We did not determine whether there were additional claims held at the plan or State level that were never submitted to T-MSIS. Additionally, we did not determine whether the claims paid for were appropriate or medically necessary. Lastly, where data were incomplete or inaccurate, we did not determine whether the error originated from the managed care plans or from the States.

## Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX A

## Number of States with incomplete or inaccurate data for the amounts paid for physician, outpatient, and laboratory services

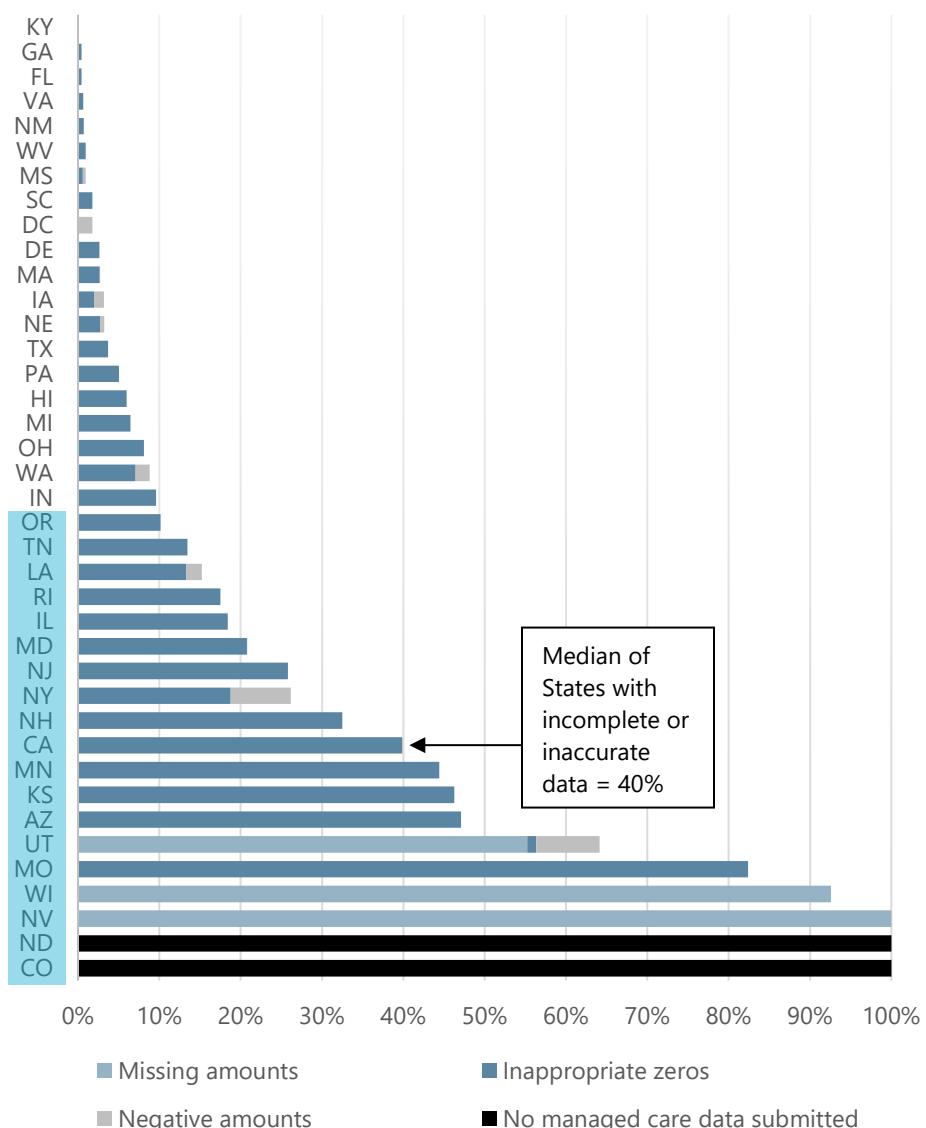
Type of service	Number of States with incomplete or inaccurate data	Percentage of claims with incomplete or inaccurate data
Physician services	23	27%
Outpatient services	17	47%
Laboratory services	13	34%

Source: OIG analysis of T-MSIS data, 2020.

Note: This analysis is based on the 31 States that indicated that claims are paid at the individual service level, as opposed to the encounter level. It is based on the largest managed care plan in each State and includes claims processed in January 2020.

# APPENDIX B

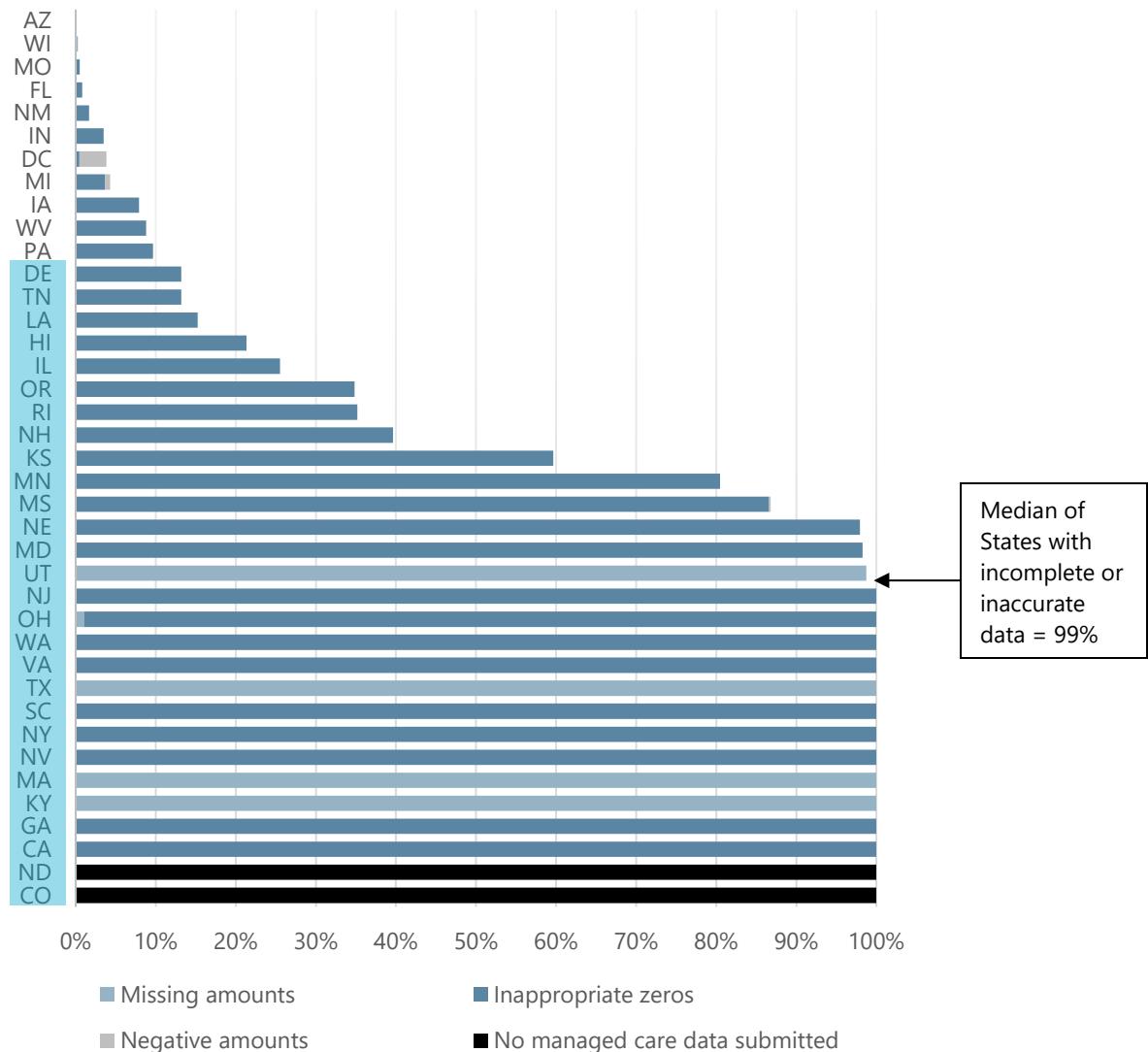
## Exhibit B-1. Percentage of incomplete or inaccurate data for amounts paid



Source: OIG analysis of T-MSIS data, 2020.

Note: This analysis is based on the largest managed care plan in each State and includes claims processed in January 2020. Highlighted States had incomplete or inaccurate data for the amounts paid for 10 percent or more of their claims.

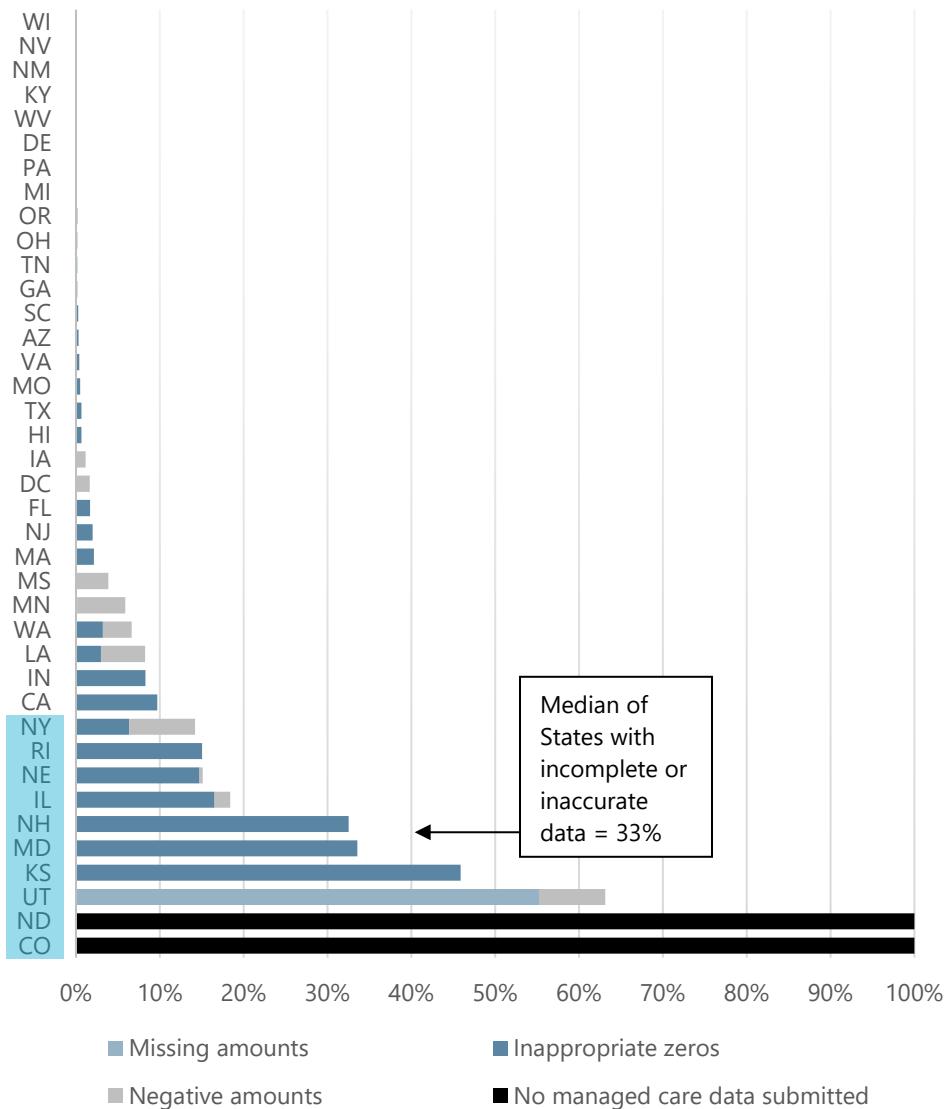
## Exhibit B-2. Percentage of incomplete or inaccurate data for amounts allowed



Source: OIG analysis of T-MSIS data, 2020.

Note: This analysis is based on the largest managed care plan in each State and includes claims processed in January 2020. Highlighted States had incomplete or inaccurate data for the amounts paid for 10 percent or more of their claims.

## Exhibit B-3. Percentage of incomplete or inaccurate data for amounts billed



Source: OIG analysis of T-MSIS data, 2020.

Note: This analysis is based on the largest managed care plan in each State and includes claims processed in January 2020. Highlighted States had incomplete or inaccurate data for the amounts paid for 10 percent or more of their claims.

# APPENDIX C: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** January 19, 2021

**TO:** Suzanne Murrin  
Deputy Inspector General for Evaluation and Inspections

**FROM:** Seema Verma  
*Seema Verma*  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Data Brief: Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate (OEI-02-19-00180)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft data brief. CMS recognizes that access to high-quality, timely data is essential for ensuring robust monitoring and oversight of the Medicaid and Children's Health Insurance Programs (CHIP), and CMS has made improving Medicaid data a top priority.

Over the past several years, CMS has worked with states to implement changes to the way in which Medicaid administrative data, including managed care payment data, is collected from states by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS). As part of the transition to T-MSIS, CMS has strengthened its reporting requirements by standardizing definitions, expanding the data being collected, adding data quality enhancements through an expansive data quality assessment and compliance process, and improving the timeliness of data submission by moving from quarterly to monthly state data submissions. Having access to more robust, timely, and accurate data via T-MSIS strengthens program monitoring, policy implementation, and oversight of Medicaid and CHIP. It also enhances CMS' and states' ability to identify potential fraud, waste, and abuse and improve program efficiency.

In May of 2017, based on feedback from users of the T-MSIS data and continuous evaluation of patterns in the data submitted to T-MSIS, CMS embarked on an initiative to help states focus on improving the accuracy and completeness of certain data elements and as such, identified 12 T-MSIS Priority Items (TPIs) necessary to support business and program oversight needs. States have made significant progress in addressing the initial TPIs, and based on additional user feedback and analytics reporting goals, CMS continued to expand the number of TPIs in 2019 and again in 2020 to include additional focus areas in support of the T-MSIS data quality continuous improvement effort. As of August 2020, CMS has identified 32 TPIs to help states improve Medicaid and CHIP data reporting accuracy and completeness, including two TPIs related to the consistency of managed care plan reporting and the completeness and consistency of payment data elements for both Fee-for-Service claims and managed care encounter data. As states make progress on current TPIs, CMS will continue to engage with stakeholders, including states, oversight entities, Congress, policy researchers, and entrepreneurs, in order to determine how to further enhance data quality improvement efforts to support business and program oversight needs.

In order to increase transparency and incentivize states' to improve data submitted, CMS has made T-MSIS data, as well as state-level data quality assessments, publicly available. For example, each state's data quality status related to 23 TPIs is published monthly on the T-MSIS page on Medicaid.gov, and CMS plans to publish state-level data quality assessments against the 2021 TPIs (24-32) on Medicaid.gov early this year. In addition, CMS created the T-MSIS Analytic Files (TAFs), which are publicly available files that include data on enrollment, demographics, service utilization, and payments in Medicaid and CHIP at the state level. CMS also published the Data Quality (DQ) Atlas, an interactive, web-based tool that helps users explore the quality and usability of the TAFs. DQ Atlas supports insightful, methodologically sound analyses of TAFs by providing data quality information on a range of key Medicaid and CHIP topics such as enrollment, claims, expenditures, and service use. The charts, maps, and tables in the DQ Atlas show state-level data quality assessments and associated measure values for topics that are pertinent to Medicaid and CHIP, including several related to managed care data.

CMS has been, and will continue to be, a committed partner with all states in support of their good-faith efforts to meet and maintain compliance with T-MSIS reporting requirements. Although CMS has partnered with states to improve data reporting, states are potentially facing limited resources to address data quality issues. Now more than ever, in light of the COVID-19 Public Health Emergency, states are facing increasing demands in implementing and operating their Medicaid and CHIP programs.

In support of state data quality efforts, CMS has provided states with tools and resources, including the T-MSIS operational dashboard and a data quality tool for identifying and resolving data quality issues. On a monthly basis, states must submit to CMS over 1,400 data elements in eight different files that make up T-MSIS. Once submitted, T-MSIS data are reviewed through two data quality methods including edits that identify basic business rule errors, and validation methods that look at patterns in each state's data in order to identify "warnings" where data elements fall outside of a normal range. These two methods are run even before a second tier of data quality review is applied to TAF files. CMS shares data quality results with states as part of its ongoing data quality monitoring efforts, and works with states to determine the priority and the timeline for resolution of any identified data quality issues. For example, in the cases of Colorado and North Dakota, which OIG noted as submitting no encounter data for their largest managed care plan in January 2020, CMS has continued to work closely with these states to address root causes of their data submission issues. In these instances, Colorado experienced a temporary two month span in which encounter data were not reported due to a system issue, which has been subsequently resolved, and North Dakota required an enhancement to their eligibility systems to be able to report any information related to the state's largest plan, which covers their Medicaid Adult Expansion population. Funding was appropriated in the June 2019 state budget for this enhancement, and after implementing their system, North Dakota began reporting encounters for the plan in the OIG's review in May 2020.<sup>1</sup>

CMS appreciates the OIG's efforts in assessing the completeness of managed care payment data in T-MSIS from January 2020 for the largest managed care plan in 39 states, and will consider how to use this information to help further improve T-MSIS data reporting. However, since OIG only looked at one plan per state for one month and did not determine whether missing data originated from the managed care plans or from the states, it is unclear whether the root cause of the issues identified is with the quality of the data submitted by specific plans to the states or with the data states submit overall to T-MSIS. As discussed above, CMS has already set priority areas for states to improve when reporting T-MSIS data, which include areas for managed care data, and will

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<sup>1</sup> [North Dakota 66th Legislative Assembly State Budget Actions for the 2019-21 Biennium](#).

continue to assess how to further expand data quality improvement efforts based on feedback from users of the T-MSIS data, including the OIG and other oversight agencies, to improve monitoring and oversight of Medicaid and CHIP.

OIG's recommendations and CMS' responses are below.

**OIG Recommendation**

CMS should review States' managed care payment data in T-MSIS and ensure that States have corrective action plans to improve data completeness and quality, as appropriate.

**CMS Response**

CMS does not concur with this recommendation. As previously mentioned, in 2017 CMS began identifying TPIs to help states focus on improving the accuracy and completeness of data elements necessary to support business and program oversight needs, and has recently expanded the number of TPIs to 32. In their recommendation, the OIG notes that CMS should accelerate and strengthen its efforts to improve the completeness and accuracy of the managed care payment data in T-MSIS, but CMS does not agree that this is an actionable or measurable recommendation, especially during a public health emergency. CMS continues to work collaboratively with states to improve the timeliness, completeness, and accuracy of T-MSIS data, while balancing these efforts with states' increasing workloads in implementing and operating their Medicaid and CHIP programs.

The OIG also notes that CMS should use its authority, as appropriate, to develop corrective action plans or to take enforcement action if states are not submitting complete and accurate managed care data. However, as part of ongoing data quality improvement, CMS has already streamlined data quality compliance and State Plans of Action (SPOAs), which currently serve as corrective action plans for states with identified data quality issues, including for managed care data. Each state's data quality status for the most recent month is published monthly on the T-MSIS page on Medicaid.gov, and CMS has found that the public reporting of each state's data quality status has also provided a strong incentive for compliance. In addition, in a March 2019 Informational Bulletin<sup>2</sup> states were made aware of enforcement actions stating that CMS may reduce enhanced Federal Financial Participation (FFP) for operational costs of systems unable to produce timely, accurate, and complete T-MSIS data. As outlined in 42 C.F.R. § 433.120, CMS may reduce FFP for expenditures for systems with non-compliant functionality, and as of March 2020, all states had met the T-MSIS reporting threshold CMS had identified in the Information Bulletin in order to maintain full federal funding. As such, CMS believes it has already fulfilled this aspect of the recommendation. CMS also ensures continuity in compliance evaluations and related enforcement, beyond reporting requirements specified in the Information Bulletin, so that states demonstrate continued commitment to improving data quality.

Finally, the OIG stated that CMS should expand its efforts by conducting reviews of T-MSIS payment data by each state's managed care plans. However, since OIG did not determine whether missing data originated from the managed care plans or from the states, it is unclear whether the root cause of the issue is with the quality of the data submitted by specific plans to the states or with the data states submit to T-MSIS. Pursuant to CMS regulatory requirements, states bear the responsibility for ensuring the quality of data submitted to T-MSIS. CMS is committed to working collaboratively with state Medicaid agencies on improving T-MSIS data quality focusing on the priority items identified. In support of state data quality efforts, CMS has provided states with tools and resources for identifying and resolving data quality issues. CMS conducts data quality reviews and shares the results with states as part of its

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<sup>2</sup> <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib031819.pdf>

ongoing data quality monitoring efforts. CMS works with states to determine root causes of their data submission issues and the priority and the timeline for resolution of identified data quality issues.

**OIG Recommendation**

CMS should make public its reviews of States' managed care payment data.

**CMS Response**

CMS does not concur with this recommendation. OIG notes that CMS should publicly report the results of its reviews of the managed care data in T-MSIS, which CMS has already done through the creation of the TAFs, which are publicly available files that include data on enrollment, demographics, service utilization, and payments, including managed care payments, in Medicaid and CHIP at the state level. Further, in order to help key stakeholders determine if the available data can meet their analytic needs, CMS created the DQ Atlas, an interactive, web-based tool that helps users explore the quality and usability of the TAFs. DQ Atlas supports insightful, methodologically sound analyses of TAFs by providing data quality information on a range of key Medicaid and CHIP topics such as enrollment, claims, expenditures, and service use. The charts, maps, and tables in DQ Atlas show state-level data quality assessments and associated measure values for topics that are pertinent to Medicaid and CHIP, including several related to managed care data.

As part of this recommendation, OIG notes that CMS should report publicly on data of individual managed care plans to improve accountability for submitting complete and accurate payment data. However, since OIG did not determine whether missing data originated from the managed care plans or from the states, it is unclear whether the root cause of the issue is with the quality of the data submitted by specific plans to the states or with the data states submit to T-MSIS. Pursuant to CMS regulatory requirements, states bear the responsibility for ensuring the quality of data submitted to T-MSIS. CMS is committed to working collaboratively with state Medicaid agencies on improving T-MSIS data quality focusing on the priority items identified. In support of state data quality efforts, CMS has provided states with numerous tools and resources for identifying and resolving data quality issues. CMS conducts data quality reviews and shares the results with states as part of its ongoing data quality monitoring efforts. CMS works with states to determine root causes of their data submission issues and the priority and the timeline for resolution of identified data quality issues.

**OIG Recommendation**

CMS should clarify and expand its initiative on payment data.

**CMS Response**

CMS does not concur with this recommendation. As noted in the OIG's report, CMS has already identified the completeness and consistency of payment data elements as a priority area, and has been assessing and documenting state compliance with this TPI since February of 2019. While CMS appreciates OIG's recommendation that CMS should expand its current initiative on payment data by measuring the completeness and accuracy of the amount allowed and holding states accountable for providing this information, it is important to note that data quality efforts must be balanced with states' increasing workloads in implementing and operating their Medicaid and CHIP programs. On a monthly basis, states must submit to CMS over 1,400 data elements, and CMS has already identified 32 TPIs to help states improve Medicaid and CHIP data reporting accuracy and completeness, including two TPIs related to the consistency of managed care plan reporting and the completeness and consistency of payment data elements for both Fee-for-Service claims and managed care encounter data. Despite the lack of a standard field for reporting the allowed amount

on managed care encounters in the files managed care plans use for the submission of data, CMS has specified at 42 C.F.R. § 438.242(c)(3) that paid and allowed amounts for managed care encounter payment data are included in the requirement for submission of “all enrollee encounter data.” A barrier to obtaining allowed amounts on encounter records is found in the role this data plays in provider contracting, as allowed amount values may impact a managed care organization’s negotiating position. There are also challenges associated with sub-capitated payment arrangements; since payment per-service is not exchanged in sub-capitation arrangements, the allowed amount detail cannot be obtained. As states make progress on current TPIs, CMS will continue to engage with stakeholders to add additional focus areas based on feedback from users of the T-MSIS data, including the OIG and other oversight agencies.

Further, CMS recognizes that additional guidance is needed to clarify how states should submit payment data to T-MSIS for managed care plans that pay providers through payment arrangements other than a per-service basis, and will continue existing plans to provide states with the necessary guidance. CMS agrees that having complete and accurate payment data in T-MSIS is essential for ensuring robust monitoring and oversight of the Medicaid and CHIP programs, and will continue to be a committed partner with all states in support of their good-faith efforts to meet and maintain compliance with the T-MSIS requirements.

# ACKNOWLEDGMENTS AND CONTACT

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To obtain additional information concerning this report, contact the Office of Public Affairs at [Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov). OIG reports and other information can be found on the OIG website at [oig.hhs.gov](http://oig.hhs.gov).

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# ENDNOTES

<sup>1</sup> We based this analysis on managed care claims for the 38 States and the District of Columbia (hereinafter referred to as States) with comprehensive, risk-based managed care. For the purposes of this report, we considered a State to have incomplete or inaccurate data if at least 10 percent of claims for its largest managed care plan were incomplete or inaccurate.

<sup>2</sup> These data do not include the capitated payment amounts that the State pays to the managed care plans.

<sup>3</sup> Jennifer L. Gerstorff and Sabrina Gibson, "Medicaid Encounter Data: The Next National Data Set," *In the Public Interest*, September 2016, pp. 6–14. Accessed at [https://milliman-cdn.azureedge.net/\\_/media/milliman/importedfiles/uploadedfiles/insight/2017/medicaid-encounter-data.ashx](https://milliman-cdn.azureedge.net/_/media/milliman/importedfiles/uploadedfiles/insight/2017/medicaid-encounter-data.ashx) on July 7, 2020.

<sup>4</sup> The paid amount is the amount that the managed care plan paid the provider and does not include any copayments made by the beneficiary or any payments made by a third party.

<sup>5</sup> Note that for each of the States that did not submit any data for its largest plan, we considered 100 percent of the State's claims to be incomplete.

<sup>6</sup> See CMS, "Top Priority Item 16: Completeness and Consistency of Claim Payment Data Elements," *CMS Guidance: Overview of Data Quality Top Priority Items*. Accessed at <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/54044> on November 9, 2020.

<sup>7</sup> In sub-capitated or similar value-based arrangements, plans pay their providers in a manner other than per service: e.g., a fixed monthly amount for each enrollee. Currently, there is no method in T-MSIS for identifying instances where plans have sub-capitated or value-based payment arrangements with providers. To account for these arrangements in our analysis, we set a generous threshold and considered a State to have incomplete or inaccurate data if at least 10 percent of claims had inappropriate zeros, missing data, or negative amounts for the amount paid.

<sup>8</sup> This analysis is based on the amount paid for individual services for outpatient and other services only. We determined the extent to which the 31 States that indicated that their plans pay claims at the individual service level—as opposed to the encounter level—had incomplete or inaccurate data.

<sup>9</sup> This analysis is based on the amount allowed for individual services for outpatient and other services only. It is based on the 31 States that indicated that their plans pay claims at the individual service level, as opposed to the encounter level.

<sup>10</sup> For sub-capitated or similar value-based arrangements, the amount billed may include zeros or missing data. To account for these instances in our analysis, we set a generous threshold and considered a State to have incomplete or inaccurate data if at least 10 percent of claims had inappropriate zeros, missing data, or negative amounts for the amount billed.

<sup>11</sup> This analysis is based on the amount billed for individual services for outpatient and other services only. It is based on the 31 States that indicated that their plans pay claims at the individual service level, as opposed to the encounter level.

<sup>12</sup> CMS, *NHE Fact Sheet*. Medicaid spending data current as of 2019. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> on March 9, 2021. See also CMS, *September 2020 Medicaid & CHIP Enrollment Data Highlights*. Accessed at <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> on March 9, 2021.

<sup>13</sup> CMS, *CMS Guidance: Overview of Data Quality Top Priority Items*. Accessed at <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/54044> on November 9, 2020.

<sup>14</sup> See OIG, *National Review of Opioid Prescribing in Medicaid Is Not Yet Possible* (OEI-05-18-00480), August 2019. See also OIG, *T-MSIS Data Not Yet Available for Overseeing Medicaid* (OEI-05-15-00050), June 2017; OIG, *Not All States Reported*

*Medicaid Managed Care Encounter Data as Required* (OEI-07-13-00120), July 2015; GAO, *Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met*, GAO-21-196, January 2021.

<sup>15</sup> OIG, *National Review of Opioid Prescribing in Medicaid Is Not Yet Possible* (OEI-05-18-00480), August 2019.

<sup>16</sup> GAO, *Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met*, GAO-21-196, January 2021.

<sup>17</sup> CMS currently does not have a method to identify all the data submitted by a plan if that plan has multiple plan identifiers. To do that, CMS needs to be able to link all plan identifiers to each managed care plan. This would allow CMS and others to easily identify data quality issues and program integrity vulnerabilities for individual plans.

<sup>18</sup> CMS has the authority to defer or disallow a portion of a State's Medicaid funding if the State does not meet all submission requirements for managed care data. See 42 CFR § 438.818(c).

<sup>19</sup> The T-MSIS Analytic Files Data Quality State snapshots are available at <https://www.medicaid.gov/dq-atlas/welcome>.

<sup>20</sup> See CMS, "Top Priority Item 16: Completeness and Consistency of Claim Payment Data Elements," *CMS Guidance: Overview of Data Quality Top Priority Items*. Accessed at <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis-blog/entry/54044> on November 9, 2020.

<sup>21</sup> Kaiser Family Foundation, *Medicaid MCO Enrollment by Plan and Parent Firm*, March 2019. Accessed at <https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-march-2019/?currentTimeframe=0&sortModel=%7B%22colId%22:%22State%22,%22sort%22:%22asc%22%7D> on September 26, 2019. We did not include prepaid ambulatory health plans, prepaid inpatient health plans, and Programs of All-Inclusive Care for the Elderly because these plans either provide a limited range of services or they provide services to a limited population.

<sup>22</sup> We identified the largest plan in each State as of October 2019.

<sup>23</sup> For six States, we were unable to identify each State's largest managed care plan because these States did not post enrollment data on their respective State websites. We surveyed each of these States to determine their largest plans.

<sup>24</sup> We used the adjudication date to determine when claims were processed for payment.

<sup>25</sup> For our analysis of the payment data, we excluded denied claims and financial transactions (i.e., capitation payments, supplemental payments, and service tracking claims).

<sup>26</sup> For the allowed amount, we excluded pharmacy claims because CMS does not expect States to submit allowed amounts for these types of claims.

<sup>27</sup> For the analysis on the amount paid, we eliminated the claims that would appropriately have \$0 in the amount paid, including claims that were denied and claims that may have been paid for by Medicare because the beneficiary had both Medicare and Medicaid coverage. We considered any zeros in the amount paid in the remaining claims over the 10 percent threshold to be inappropriate. In addition, negative paid amounts may occur in rare instances; these payments may indicate money owed to the plan by the provider typically as a result of an overpayment on a prior claim. We considered any negative payments over the 10 percent threshold to be inappropriate. We applied the same 10 percent threshold to the amounts allowed and billed.