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Report to the Ranking Member, Committee on Finance, U.S. Senate

October 2012

MEDICAID

Data Sets Provide Inconsistent Picture of Expenditures

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Accountability * Integrity * Reliability

GAO-13-47

October 2012

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Data Sets Provide Inconsistent Picture of Expenditures

Highlights of GAO-13-47, a report to the Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

CMS, within the Department of Health and Human Services, and state Medicaid agencies jointly administer the multibillion-dollar Medicaid program, which finances health care for certain low-income individuals. Medicaid is on GAO's high-risk list because of vulnerabilities to waste, fraud, abuse, and mismanagement. CMS has two data sets that report state Medicaid expenditures. The MSIS data set is designed to report individual beneficiary claims data. The CMS-64 data set aggregates states' expenditures, which are used to reimburse the states for their Medicaid expenditures. However, neither data set provides a complete picture of Medicaid expenditures.

GAO was asked to compare MSIS and CMS-64 data. This report (1) examines the extent to which MSIS and CMS-64 expenditure data differ and (2) where possible, quantifies the identified differences between the two data sets. GAO reviewed documents, compared Medicaid expenditure data, and interviewed CMS and state officials. GAO used fiscal years 2007 through 2009 data—the most-recent and most-complete data available.

View GAO-13-47. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Medicaid expenditures in the Medicaid Statistical Information System (MSIS) were generally less than CMS-64 amounts. National expenditures in MSIS were 86, 87, and 88 percent of the amounts in CMS-64 in fiscal years 2007 through 2009, respectively. In fiscal year 2009, MSIS expenditures for states ranged from 59 to 119 percent of CMS-64. Specifically, 40 states reported lower expenditures in MSIS than CMS-64; 5 states and the District of Columbia reported higher expenditures; and 5 states reported similar levels of expenditures.

Total Medicaid Expenditures in MSIS and CMS-64, Fiscal Years 2007-2009

Fiscal year	MSIS expenditures (dollars in billions)	CMS-64 expenditures (dollars in billions)	Difference between MSIS and CMS-64 (dollars in billions)	MSIS as a percentage of CMS-64 expenditures
2007	$273.9	$320.1	$46.1	86%
2008	294.2	338.6	44.4	87
2009	323.1	366.5	43.4	88

Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: MSIS and CMS-64 expenditures were rounded.

GAO was able to quantify some, but not all, of the identified differences in expenditures between MSIS and the CMS-64.

- GAO adjusted MSIS for expenditures that were not attributed to individual beneficiaries—such as prescription drug rebates. These adjustments increased MSIS to 92, 93, and 94 percent of the amounts in CMS-64 in fiscal years 2007 through 2009, respectively.

- GAO could not account for the remaining differences in part because of inconsistencies in the Centers for Medicare & Medicaid (CMS) guidance between the two data sets. For example, CMS officials explained that expenditures for inpatient services as reported by a state in MSIS and as reported in CMS-64 are not necessarily for the same services.

GAO also found that states do not submit timely MSIS information. CMS requires states to submit MSIS data within 45 days and CMS-64 data within 30 days of the end of the quarter. However, states' reporting of MSIS data can be up to 3 years late, whereas CMS-64 data are consistently reported on time. Also, MSIS expenditure data are considered less reliable when compared with CMS-64.

GAO has reported that CMS will need more reliable data for assessing expenditures and measuring performance in the Medicaid program. MSIS and CMS-64 have the potential to offer a robust view of the Medicaid program, enhancing CMS oversight of aggregate spending trends, per beneficiary spending growth, and cross-state comparisons, all of which could be useful in improving the financial integrity of this high-risk program. However, delays in reporting MSIS data and inconsistencies between the two data sets limit their usefulness as oversight tools. CMS has recently completed a pilot study aimed in part at improving the timeliness and consistency of both systems data.

HHS provided technical comments on a draft of this report, which were incorporated as appropriate.

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Abbreviations

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
FPL	federal poverty level
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
LTSS	long-term support services
M-CHIP	Medicaid Expansion Children's Health Insurance Program
MSIS	Medicaid Statistical Information System
PPACA	Patient Protection and Affordable Care Act
S-CHIP	Separate Children's Health Insurance Program

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

October 29, 2012

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate

Dear Senator Hatch:

The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), and state Medicaid agencies jointly administer the multibillion-dollar Medicaid program, which finances health care for approximately 67 million low-income individuals who meet specific eligibility criteria. In recent years, the Medicaid program has undergone steady growth and is expected to continue to expand in light of the Patient Protection and Affordable Care Act of 2010 (PPACA).[1] PPACA expands eligibility for Medicaid to nonelderly individuals whose income does not exceed 133 percent of the federal poverty level (FPL),[2] or $30,700 for a family of four in 2012.[3] However, because states may choose not to participate in the PPACA expansion, it is unclear how much the Medicaid program will grow.[4]

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

[2]PPACA § 2001(a)(1), 124 Stat. 271.

[3]We use FPL to refer to federal poverty guidelines issued by HHS each year in the Federal Register. These guidelines provide income thresholds that vary by family size and for certain states, and which are updated using the Consumer Price Index.

[4]Under the Medicaid program, failure by a state to comply with federal requirements may result in a termination of federal Medicaid matching funds. However, the U.S. Supreme Court has ruled that states that choose not to expand Medicaid eligibility to these newly eligible individuals under PPACA will forgoe only the matching funds associated with such expanded coverage. See *National Federation of Independent Business, et al., vs. Sebelius, Sec. of Health and Human Services, et al.*, 567 U.S. __, 2012 WL 2427810 (U.S. June 28, 2012). Prior to the Supreme Court decision, the CMS Actuary estimated the PPACA Medicaid expansion would enroll an additional 15 million individuals in 2014. However, in July 2012 the Congressional Budget Office estimated that an additional 7 million individuals would enroll in Medicaid and the Children's Health Insurance Program (CHIP) in 2014.

Medicaid is on our high-risk list in part because of concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate spending.[5] We have previously reported that Medicaid has among the highest estimated improper payments of any federal program reporting such data. Consequently, we have reported that, particularly as PPACA is implemented, CMS will need new tools and resources, including more reliable data for assessing expenditures and measuring performance.[6]

CMS has two data sets that report state Medicaid expenditures, but the data sets have different purposes and limitations. Consequently, neither data set provides a complete picture of Medicaid expenditures.

- The Medicaid Statistical Information System (MSIS) was established as a national eligibility and claims data set, and can provide CMS a summary of expenditures linked to specific beneficiaries on the basis of their medical claims for care.[7] CMS reviews these data for reliability, and uses these data for policy analysis, program utilization, and forecasting expenditures. However, these data exclude other aspects of the Medicaid program that are not tied to specific beneficiaries. For example, the MSIS data set does not contain supplemental payments to providers that are separate from standard Medicaid payments for services.

- The CMS-64 data set aggregates states' expenditures, which are used to reimburse the states for their federal shares of Medicaid expenditures.[8] CMS reviews these submissions, and the data are the

[5]Our list identifies areas that are at high risk because of their greater vulnerabilities to waste, fraud, abuse, and mismanagement or major challenges associated with their economy, efficiency, or effectiveness.

[6]See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

[7]States are required to have in operation a mechanized claims-processing and information-retrieval system based on certain federal requirements. *See* 42 U.S.C. § 1396b(r). For all claims filed on or after January 1, 1999, states have been required to electronically transmit claims data, including detailed individual enrollee encounter data in a format consistent with MSIS. *See* 42 U.S.C. § 1396b(r)(1)(F).

[8]For purposes of this report, we refer to form CMS-64 as "CMS-64." The form CMS-64 is titled the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The information is stored in a data set called the Medicaid Budget and Expenditure System. States are required to submit aggregate total quarterly Medicaid expenditures on the form CMS-64 no later than 30 days after the end of each quarter. 42 C.F.R. § 430.30 (2011).

most-reliable accounting of total Medicaid expenditures. However, these data exclude beneficiary-specific data and thus have limited use in examining program spending. For example, CMS cannot use CMS-64 data to conduct a beneficiary-level analysis to identify program spending abuses in particular service areas, such as prescription drugs.[9]

Total Medicaid expenditure data, nationally and by state, often differ widely between MSIS and CMS-64, even after accounting for differences between the two in the purpose of the database and the type of information provided. Members of Congress, industry experts, and researchers have noted that these two sets of expenditure data cannot be easily reconciled, thus limiting CMS oversight. For example, differences in expenditure data between the two data sets limit CMS's ability to conduct cross-state comparisons of Medicaid spending. Such comparisons could be used to analyze Medicaid spending patterns by eligibility group and other enrollee characteristics that could be useful in improving the financial integrity of this high-risk program. To better understand the strengths and limitations of federal data on Medicaid expenditures, you requested that we study the similarities and differences between MSIS and CMS-64. In this report, we (1) examine the extent to which MSIS and CMS-64 data on Medicaid expenditures differ nationally, by state, and by expenditure category for fiscal years 2007 through 2009; and (2) where possible, quantify identified differences between these two data sets.

To determine the extent to which data on Medicaid expenditures differ, we examined CMS data on total Medicaid expenditures, as reported by states in MSIS and CMS-64, nationally, by state, and by expenditure category for fiscal years 2007 through 2009.[10] We used these fiscal years because they were the most-recent and most-complete data available at the time of our analysis. We examined total MSIS and CMS-64 expenditures, nationally and by state, by comparing the expenditures reported by states in MSIS as a percentage of those reported in CMS-64.

[9]See GAO, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions,* GAO-12-201 (Washington, D.C.: Dec. 14, 2011).

[10]In this report, we use the term "state" to refer to the 50 states and the District of Columbia. We do not include Medicaid administrative expenditures, state collections, or expenditures from Puerto Rico or the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, or the U.S. Virgin Islands (which have Medicaid programs) because they were not reported in MSIS during fiscal years 2007 through 2009.

We provide results for fiscal years 2007 through 2009, and provide additional detail for the most recent year available, fiscal year 2009. We also combined the individual service types in MSIS and CMS-64 into six combined expenditure categories.[11] This was necessary because, in many instances, there is not a one-to-one match of service types in MSIS and CMS-64. As a result, we were able to report on expenditures by combined expenditure categories, and thereby better identify the factors that account for the differences between MSIS and CMS-64. We compared expenditures by combined expenditure categories nationally and by state.

To examine and, where possible, quantify the identified differences between MSIS and CMS-64 data, we identified and analyzed differences in the types of expenditures included in each data set. Where possible, we adjusted the MSIS expenditures on the basis of the differences we identified, adding expenditures reported in CMS-64 that were not reported in MSIS to obtain total adjusted expenditures for MSIS. We then took the total adjusted expenditures nationally, and by state, and calculated the expenditures reported in MSIS as a percentage of those reported in CMS-64. We also compared adjusted expenditures by combining expenditure categories, nationally and by state. We identified additional factors that accounted for differences between the two data sets, but could not be quantified.

For both objectives, we reviewed relevant guidance and documentation, including CMS forms and data dictionaries, and also interviewed CMS officials and other experts familiar with Medicaid expenditure data. We reviewed the data for reasonableness and consistency, including screening for missing data, outliers, and obvious errors. We also interviewed CMS officials about steps they take to ensure data reliability. We determined that these data were sufficiently reliable for our purposes. We also interviewed a judgmental sample of state Medicaid agencies to help illustrate specific factors that account for the differences in reported Medicaid expenditures. We chose the judgmental sample on the basis of

[11]While we are matching services between these two data sets, some of the expenditures we describe here are not directly tied to a Medicaid service in MSIS, such as Medicaid payments for Medicare premiums. Other examples of individual service types are inpatient hospital, nursing facility, transportation, and rural health clinic screenings. Our six combined expenditure categories are (1) hospital, (2) acute and long-term support services—noninstitutional, (3) drugs, (4) managed care and Medicaid premium assistance, (5) long-term support services—institutional, and (6) Medicare.

a variety of criteria using the most-recent and most-complete data available, including the size of their total adjusted Medicaid expenditures, adjusted MSIS expenditures as a percentage of CMS-64 expenditures, and geographic variation. A detailed discussion of our scope and methodology is presented in appendix I.

We conducted this performance audit from March 2012 through September 2012 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

Medicaid is a health care program jointly funded by the federal government and states to provide care for certain low-income individuals. The federal government oversees states' Medicaid programs, and typically pays from 50 to 83 percent of each state's allowable Medicaid costs.[12] Medicaid enrollees are entitled to receive a range of medical services, including hospital care, physician services, laboratory and other diagnostic tests, prescription drugs, dental care, and long-term care services. In addition, Medicaid provides assistance to low-income elderly individuals who are also eligible for Medicare, called "dual eligibles."[13] This assistance can include covering Medicare premiums and cost sharing.

[12]In general, state Medicaid spending is matched by the federal government at a rate that is based, in part, on each state's per capita income according to a formula established by law. The federal share of Medicaid expenditures, known as the federal medical assistance program, typically ranges from 50 to 83 percent. The federal government pays a larger portion of Medicaid expenditures in states with low per-capita income relative to the national average, and a smaller portion for states with higher per-capita incomes. In fiscal year 2012, the largest federal portion was 74.18 percent.

[13]Medicare is the federal health insurance program that covers seniors aged 65 and older, and some disabled persons.

Medicaid Expenditure Data

MSIS is a national Medicaid eligibility and claims data set, and is the federal source of Medicaid expenditure data that can be linked to a specific enrollee. State Medicaid agencies are required to provide CMS, through MSIS, quarterly electronic files approximately 45 days after a quarter has ended. These files contain: (1) persons covered by Medicaid, known as "eligible files"; and (2) adjudicated claims, known as the "paid claims file," for medical services reimbursed by the Medicaid program. Each state's eligible file contains one record for each person covered by Medicaid for at least 1 day during the reporting quarter. Individual eligible files consist of demographic and monthly enrollment data. Paid claims files contain information on medical service-related claims and capitation payments.[14]

MSIS data include enrollees' eligibility status for Medicaid and the Children's Health Insurance Program (CHIP), types of services received by enrollees, and expenditure data. MSIS data are used for policy analysis, program utilization, and forecasting expenditures. However, MSIS data are not used to determine the federal share of Medicaid expenditures, and are not used by the states to manage the daily operations of their Medicaid programs.

The CMS-64 data set contains program-benefit costs and administrative expenses that are not linked to individual enrollees. State Medicaid agencies submit this information 30 days after a quarter has ended by means of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program—also known as the form CMS-64—within the Medicaid Budget and Expenditure System. CMS-64 data are reported at a state aggregate level, such as a state's total expenditures for such categories as inpatient hospital services and prescription drugs. Therefore, unlike MSIS, these data do not include individual expenditure data on the state's enrollees or the services they received under Medicaid. Also unlike MSIS, CMS-64 contains expenditures that are not linked to specific enrollees, such as supplemental payments including Disproportionate Share Hospital (DSH) payments.[15] CMS-64 data are the

[14]Capitation payments are specified amounts of money paid to a health plan or doctor. These payments are used to cover the cost of a health plan member's health care services for a certain length of time.

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

most-reliable and most-comprehensive information on Medicaid spending. Agency officials review expenditures submitted through CMS-64, and use the data to compute the federal financial participation for each state's Medicaid program costs.

Medicaid: A High-Risk Program

Our reports have demonstrated the need for CMS to improve its oversight of this growing, complex program. In particular, federal internal-control standards, as documented in GAO's *Standards for Internal Control in the Federal Government*, state that program managers need both operational and financial data to determine whether they are meeting their goals for accountability and efficient use of resources in order to make operating decisions, monitor performance, and allocate resources. Pertinent information should be identified, captured, and distributed in a form and time frame that permits people to perform their duties efficiently.[16] These reports have also identified shortcomings with the MSIS and CMS-64 data sets, particularly in two areas: Medicaid program integrity and supplemental payments.[17]

We recently issued a report that found that the majority of CMS's Medicaid Integrity Group audits through February 2012 relied on MSIS data, although CMS officials told us that they recently reduced their reliance on MSIS data for these audits.[18] We noted that MSIS is an extract of states' claims data and is missing key elements, such as provider names, that are necessary for auditing. Furthermore, we found that the median amount of the potential overpayment identified in MSIS was relatively small compared with other types of audits that used state-based data sets. We recommended, and HHS partially concurred, that the CMS Administrator ensure that the program-integrity group's update of its comprehensive plan provide key details about the audit program,

[16]GAO, *Internal Control: Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[17]In addition to studies regarding Medicaid program integrity and supplemental payments, as discussed below, our high-risk report also indicated that Medicaid demonstration projects were an area of concern. See GAO-11-278.

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

including its expenditures and audit outcomes, program improvements, and plans for effectively monitoring the program.

We also recently reported that the accountability and transparency of supplemental payments have been lacking using CMS-64.[19] Specifically, our work found that states reported $32 billion in DSH and non-DSH Medicaid supplemental payments during fiscal year 2010. However, the exact amount of supplemental payments is unknown using CMS-64 because not all states reported their non-DSH supplemental payments separately from their regular payments. In an earlier report, we also found that information on non-DSH supplemental payments was incomplete because states did not provide full information to CMS regarding these payments. We noted that until reliable and complete information on states' supplemental payments is available, federal officials overseeing the program and others will lack the information they need to review payments and ensure that they are appropriately spent for Medicaid purposes.

MSIS Medicaid Expenditures Amounts Are Generally Less than CMS-64 Expenditure Amounts

MSIS Medicaid expenditure amounts nationwide were generally less than CMS-64 amounts. For fiscal years 2007, 2008, and 2009, total expenditures based on MSIS data for the nation were 86, 87, and 88 percent, respectively, of the amounts shown in CMS-64. In fiscal years 2007 through 2009, the difference in Medicaid expenditures between the two data sets decreased from about $46 billion in fiscal year 2007 to $43 billion in fiscal year 2009. For fiscal year 2009, the most-recent and most-complete data available, MSIS showed $323 billion in total expenditures compared with the $366 billion in CMS-64, a difference of $43 billion. (See table 1.)

[19]Supplemental payments are payments separate from and in addition to those made at a state's standard Medicaid payment rate and include DSH payments. DSH payments are made to hospitals that treat large numbers of Medicaid and uninsured individuals. Other supplemental payments, or non-DSH payments, are made to providers above the standard Medicaid payment rates but within the Upper Payment Limit, which is the estimated amount that Medicare pays for comparable services. States have made non-DSH supplemental payments to hospitals, nursing homes, physician groups, and other Medicaid providers. See GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years*, GAO-12-694 (Washington, D.C.: July 20, 2012) and *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614 (Washington, D.C.: May 30, 2008).

Table 1: Total Medicaid Expenditures in the Medicaid Statistical Information System (MSIS) and CMS-64, Fiscal Years 2007-2009

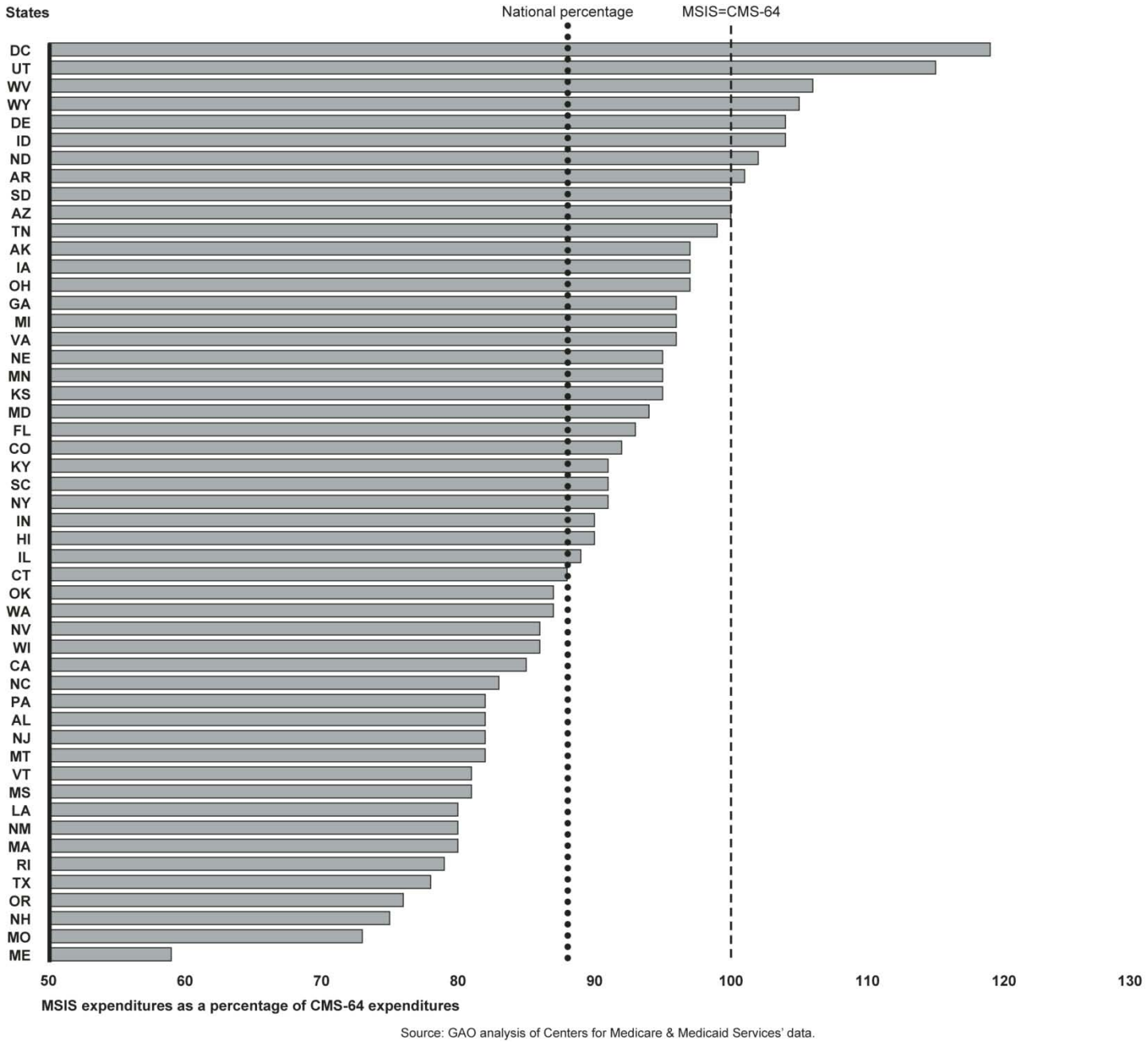
Fiscal year	MSIS baseline (dollars)	CMS-64 baseline (dollars)	Difference between MSIS baseline and CMS-64 baseline (dollars)	MSIS baseline as a percentage of CMS-64 (percent)
2007	$273,925,484,790	$320,052,492,375	$46,127,007,585	86%
2008	294,167,348,289	338,552,036,761	44,384,688,472	87
2009	323,120,029,363	366,486,147,093	43,366,117,730	88

Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

MSIS Medicaid expenditures for individual states were generally less than CMS-64 amounts. In fiscal years 2007 through 2009, states' MSIS Medicaid expenditures ranged from 59 percent to 120 percent compared with CMS-64. In fiscal year 2009 alone, states' MSIS Medicaid expenditures ranged from 59 to 119 percent of those in CMS-64. (See fig. 1.) Specifically, MSIS Medicaid expenditures were less than CMS-64 amounts in 40 states. These expenditures were greater than CMS-64 expenditures in 6 states, and were similar to CMS-64 expenditures in 5 states.[20] See appendix II for a table of total baseline state expenditures reported in MSIS and CMS-64 by dollar amount in fiscal year 2009.

[20]For purposes of this report, we defined "similar" to include MSIS expenditures within 98 to 102 percent of CMS-64 expenditures.

Figure 1: Medicaid Statistical Information System (MSIS) Medicaid Expenditures as a Percentage of CMS-64 Expenditures, by State, Fiscal Year 2009

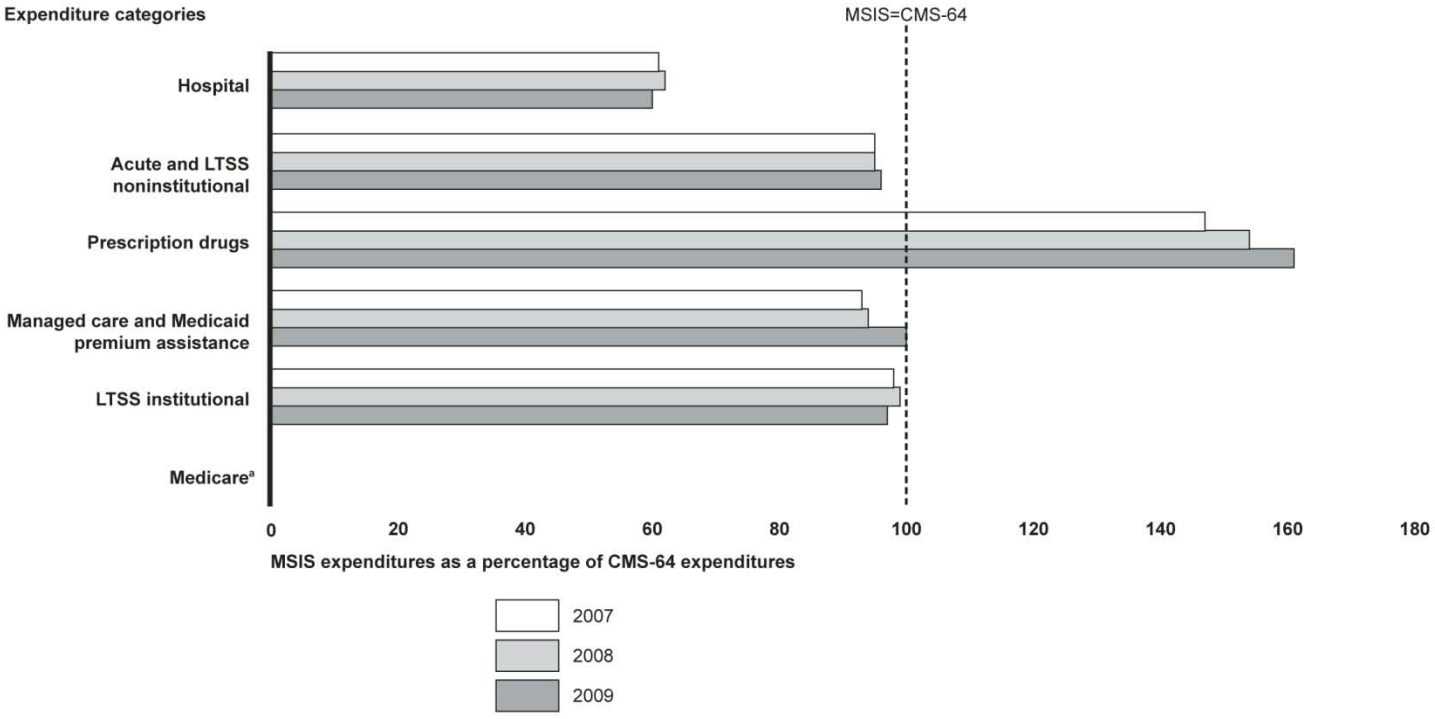


Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

We found differences in Medicaid expenditures between the two data sets when we combined MSIS and CMS-64 services types into our six combined expenditure categories: (1) hospital, (2) acute or long-term support services (LTSS)-noninstitutional, (3) prescription drugs, (4) managed care and Medicaid premium assistance, (5) LTSS-institutional, and (6) Medicare.[21] For example, MSIS Medicaid expenditure data in the hospital expenditure category were less than the amounts shown in CMS-64, at 61, 62, and 60 percent, respectively, for fiscal years 2007, 2008, and 2009. Conversely, MSIS Medicaid expenditures related to the prescription-drug category were greater than the amounts shown in CMS-64 data, at 147, 154, and 161 percent for the same period. During this time, states did not report expenditures for Medicare premiums in MSIS. However, expenditures associated with Medicare coinsurance and deductibles were reported under individual services throughout MSIS and therefore not identified as Medicare expenditures. As a result, MSIS expenditures as a percent of CMS-64 in the Medicare category are reported as 0 percent. (See fig. 2.)

[21]Medicaid provides assistance to low-income elderly individuals who are also eligible for Medicare, called “dual eligibles.” This assistance can include covering Medicare premiums and cost sharing.

Figure 2: MSIS Medicaid Expenditures as a Percentage of CMS-64 Expenditures, by Expenditure Category, Fiscal Years 2007–2009



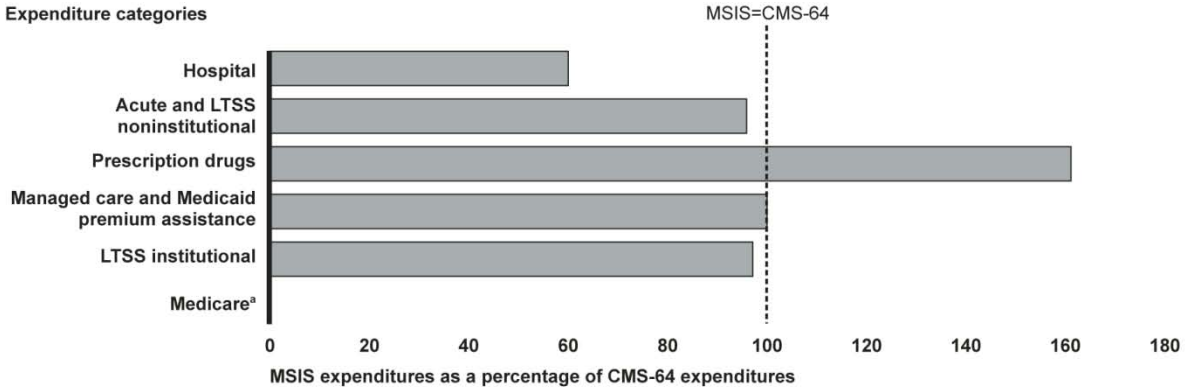
Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: LTSS stands for long-term support services.

[a]The Medicare expenditure category is reported at $0 in the Medicaid Statistical Information System (MSIS). During this period, states did not report expenditures for Medicare premiums in MSIS. However, expenditures associated with Medicare coinsurance and deductibles were reported under individual services throughout MSIS and therefore not identified as a Medicare expenditure.

For fiscal year 2009, Medicaid expenditures in MSIS were lower than CMS-64 for four of the six expenditure categories: hospital, acute and LTSS-noninstitutional, LTSS-institutional, and Medicare. The hospital, prescription drugs, and Medicare categories showed the largest difference between what was reported in MSIS compared with CMS-64, for fiscal year 2009. In particular, Medicaid hospital expenditures in MSIS were 60 percent of those reported in CMS-64, in fiscal year 2009. Medicare expenditures were reported as $0 in MSIS, compared with $12 billion in CMS-64. For the remaining two categories, prescription drug expenditures in MSIS were 61 percent larger in MSIS than in CMS-64, while managed care and Medicaid premium assistance MSIS expenditures were similar to those in CMS-64. (See fig. 3.)

Figure 3: MSIS Medicaid Expenditures as a Percentage of CMS-64 Expenditures, by Expenditure Category, Fiscal Year 2009



Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: LTSS stands for long-term support services.

[a]The Medicare expenditure category is reported at $0 in the Medicaid Statistical Information System (MSIS). During this period, states did not report expenditures for Medicare premiums in MSIS. However, expenditures associated with Medicare coinsurance and deductibles were reported under individual services throughout MSIS and therefore not identified as a Medicare expenditure.

Some Factors Could Be Quantified and Accounted for Approximately Half of the Expenditure Difference between the Data Sets

Some—but not all—factors could be quantified to narrow the difference between MSIS and CMS-64 expenditures. In particular, we adjusted for expenditures that could not be attributed to individual beneficiaries—one of the key differences in the design of the data sets. However, we could not quantify the effect of other factors, such as inconsistent CMS guidance across the two data sets.

Differences Attributable to the Design of the Data Sets Could Be Quantified and Adjusted

MSIS is designed to report claims data, and CMS-64 is designed to reimburse states for their federal share of Medicaid expenditures. As we have noted, some expenditures that are required to be reported in CMS-64 do not appear in MSIS, such as when the expenditure is not tied to an individual enrollee's claim. After adjusting the MSIS data to include expenditures for factors not related to individual enrollees' claims, Medicaid expenditures for the nation based on MSIS data were 92, 93, and 94 percent of amounts shown in CMS-64 data, respectively, for fiscal years 2007, 2008, and 2009. (See table 2.)

Table 2: Total Medicaid Expenditures Adjusted in the Medicaid Statistical Information System (MSIS) and CMS-64, Fiscal Years 2007–2009

Fiscal year	MSIS adjusted (dollars)	CMS-64 baseline (dollars)	Difference between MSIS adjusted and CMS-64 baseline (dollars)	MSIS baseline as a percentage of CMS-64 (percent)
2007	$294,595,771,198	$320,052,492,375	$25,456,721,177	92%
2008	315,779,358,947	338,552,036,761	22,772,677,814	93
2009	345,172,184,969	366,486,147,093	21,313,962,124	94

Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

For fiscal year 2009, we were able to adjust MSIS data for four factors: DSH payments, Medicare premiums, national and state rebates for prescription drugs, and Medicaid health insurance payments. None of these factors were reported in MSIS because CMS officials indicated they were not attributed to an individual enrollee.

- DSH payments were included under the hospital expenditure category in CMS-64, but not in MSIS.[22] We adjusted MSIS expenditure data to account for DSH payments to hospitals. For example, in fiscal year 2009, states reported approximately $88 billion in total hospital expenditures on CMS-64, which included approximately $18 billion for DSH payments. Total hospital expenditures in MSIS were at about $53 billion. Adding the $18 billion in DSH payments to total hospital expenditures in MSIS increased the percentage of MSIS expenditures from 60 percent of CMS-64 expenditures to 81 percent. Even after this adjustment, MSIS hospital expenditures are $17 billion lower than those on CMS-64, indicating that there are additional factors that account for the difference in hospital-related expenditures between the two data sets.[23]

[22]In fiscal years 2007 through 2009, the CMS-64 included expenditures for DSH payments on line 1B for Inpatient Hospitals and 2B for Mental Health Facilities on the CMS-64, but these were not reported in MSIS.

[23]Totals do not add up due to rounding.

- Medicare premiums were included in CMS-64, but CMS did not require states to report them in MSIS.[24] In addition, Medicaid payments for enrollees with Medicare coinsurance and deductibles are included in MSIS, but within the various service types, and cannot be distinguished from other expenditures.[25] In fiscal year 2009, total expenditures for Medicare as reported on CMS-64 were approximately $11 billion, whereas MSIS expenditures for the Medicare category were $0. Adjusting for the approximately $11 billion reported in fiscal year 2009 for Medicare premiums in CMS-64 increased the percentage of total Medicare expenditures in MSIS from 0 percent of CMS-64 expenditures to 92 percent, or a difference of $908 million. Thus, the primary factor that accounted for the difference in Medicare expenditures between the two data sets can be attributed to the absence of Medicare premium expenditures in MSIS.

- Prescription drug rebates were included in CMS-64, but CMS did not require states to report them in MSIS.[26] Prescription drug rebates are made by drug manufacturers to states in a lump sum payment for Medicaid enrollees who use specific drugs, and therefore are not connected to individual claims. In fiscal year 2009, total expenditures for the prescription drugs category, as reported on CMS-64, were initially about $25 billion. However, there was a reduction to $16 billion when $10 billion dollars in national and state prescription drug rebates

[24]In fiscal years 2007 through 2009, the CMS-64 included expenditures for Medicare on lines 17A–D of the CMS-64, including rows for Medicare premiums, but the expenditures were not reported in MSIS. See line 17A for Medicare Health Insurance Payments Part A premiums, line 17B for Medicare Health Insurance Payments Part B premiums, line 17C1 for 120–134 percent of the poverty level, line 17C2 for 135–175 percent of the poverty level.

[25]In fiscal years 2007 through 2009, while MSIS did not include Medicare premiums, both CMS-64 and MSIS did include Medicaid expenditures for Medicare coinsurance and deductibles. However, MSIS includes these expenditures within the various expenditure types. Therefore, these expenditures cannot be tracked as a Medicare coinsurance or deductible using the MSIS annual person summary file. As a result, since expenditures from Medicare coinsurance and deductibles exist in MSIS, but are not captured in the Medicare category, we did not adjust for this, as doing so would double count these expenditures. In fiscal year 2009, the amount for Medicare coinsurance and deductibles in CMS-64 was approximately $908 million.

[26]In fiscal years 2007 through 2009, the CMS-64 included expenditures for prescription drug rebate offsets on rows 7A1 for national agreements and 7A2 for state side bar agreements of the CMS-64, but these were not reported in MSIS.

were included.[27] Total prescription drug expenditures in MSIS were approximately $25 billion. Adjusting for the $10 billion reported for prescription drug rebates in CMS-64 decreased the percentage of MSIS expenditures from 161 percent of CMS-64 expenditures to 99 percent of CMS-64 expenditures. Thus, the difference in reported prescription drug expenditures can be almost entirely attributed to the rebates.[28]

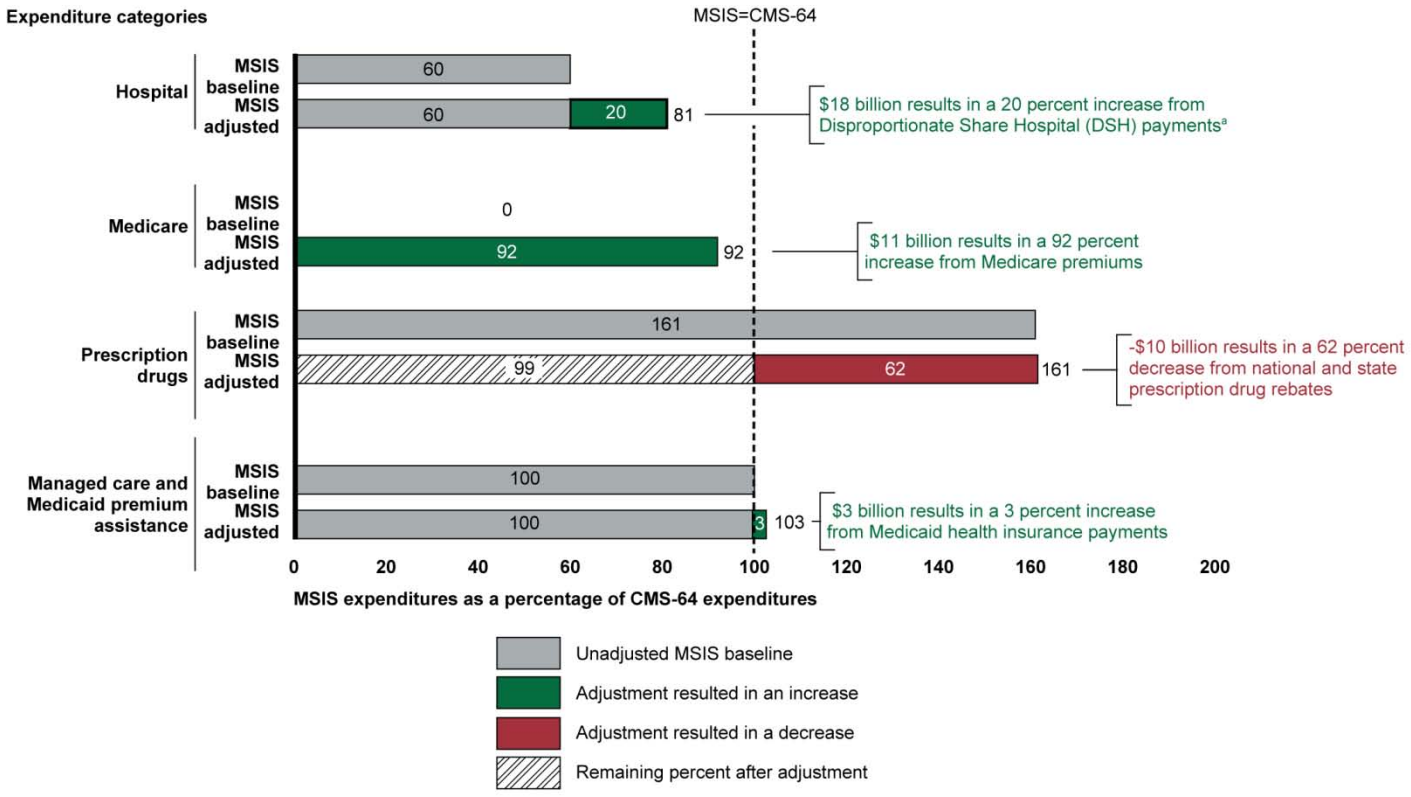
- Some Medicaid health insurance payments were included in CMS-64 that CMS did not require states to report in MSIS.[29] In fiscal year 2009, total expenditures for the managed care and Medicaid premium assistance expenditure category, as reported on CMS-64, were approximately $82 billion, of which $3 billion were for Medicaid health insurance payments not reported in MSIS. Total managed care and Medicaid premium assistance expenditures, as reported in MSIS, were approximately $85 billion. Adjusting for the roughly $3 billion for Medicaid health insurance payments increased the percentage of MSIS expenditures from 100 percent of CMS-64 expenditures to more than 103 percent. Therefore, total managed care and Medicaid premium assistance expenditures in MSIS were greater than those reported in CMS-64. (Fig. 4 compares the MSIS baseline to the MSIS adjusted expenditures as a percentage of CMS-64, by expenditure category, for fiscal year 2009.)

[27]Totals do not add up due to rounding.

[28]CMS officials told us that some states did include rebates in their MSIS totals. We were unable to adjust for these since MSIS is not set up to separate rebates from other reported data.

[29]In fiscal years 2007 through 2009, the CMS-64 included expenditures for Medicaid health insurance payments on rows 18C (Medicaid health insurance payments–Group Health Plan Payments), 18D (Medicaid health insurance payments–Coinsurance and Deductibles) and 18E (Medicaid health insurance payments–Other), but these were not reported in MSIS.

Figure 4: Comparison of MSIS Baseline to Adjusted Expenditures, by Expenditure Category, as a Percentage of CMS-64, Fiscal Year 2009

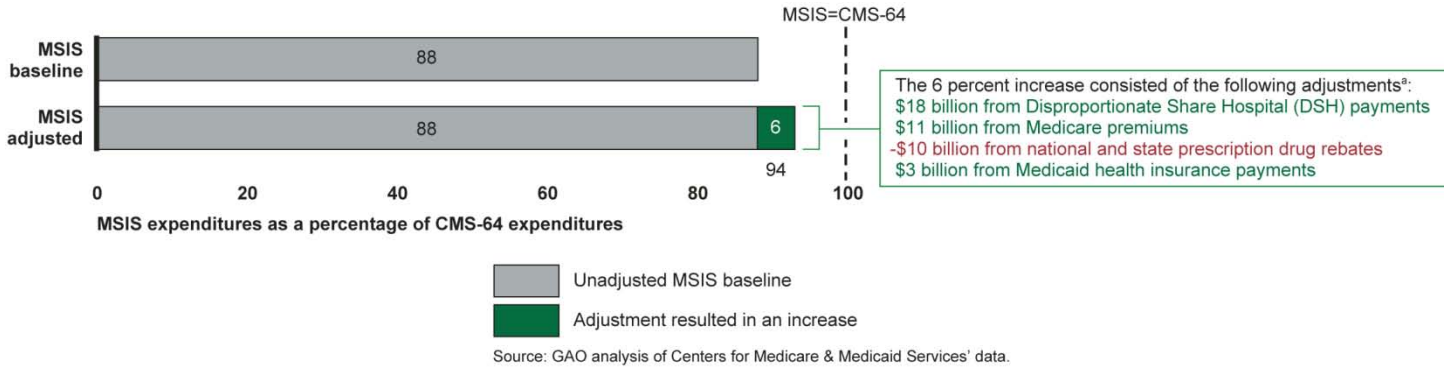


Source: GAO analysis of Centers & Medicaid Services' data.

[a]Adjustments were made by including reported CMS-64 dollars in the Medicaid Statistical Information System (MSIS).

Overall, for fiscal year 2009, the difference in Medicaid expenditures, after adjustments, decreased from $43 billion to $21 billion nationally. As a result, MSIS expenditures as a percentage of CMS-64 for the nation increased 6 percentage points from 88 percent to 94 percent—thereby reducing the difference in reported expenditures by half. (See fig. 5.)

Figure 5: Comparison of MSIS Baseline to MSIS Adjusted Expenditures, as a Percentage of CMS-64, Fiscal Year 2009

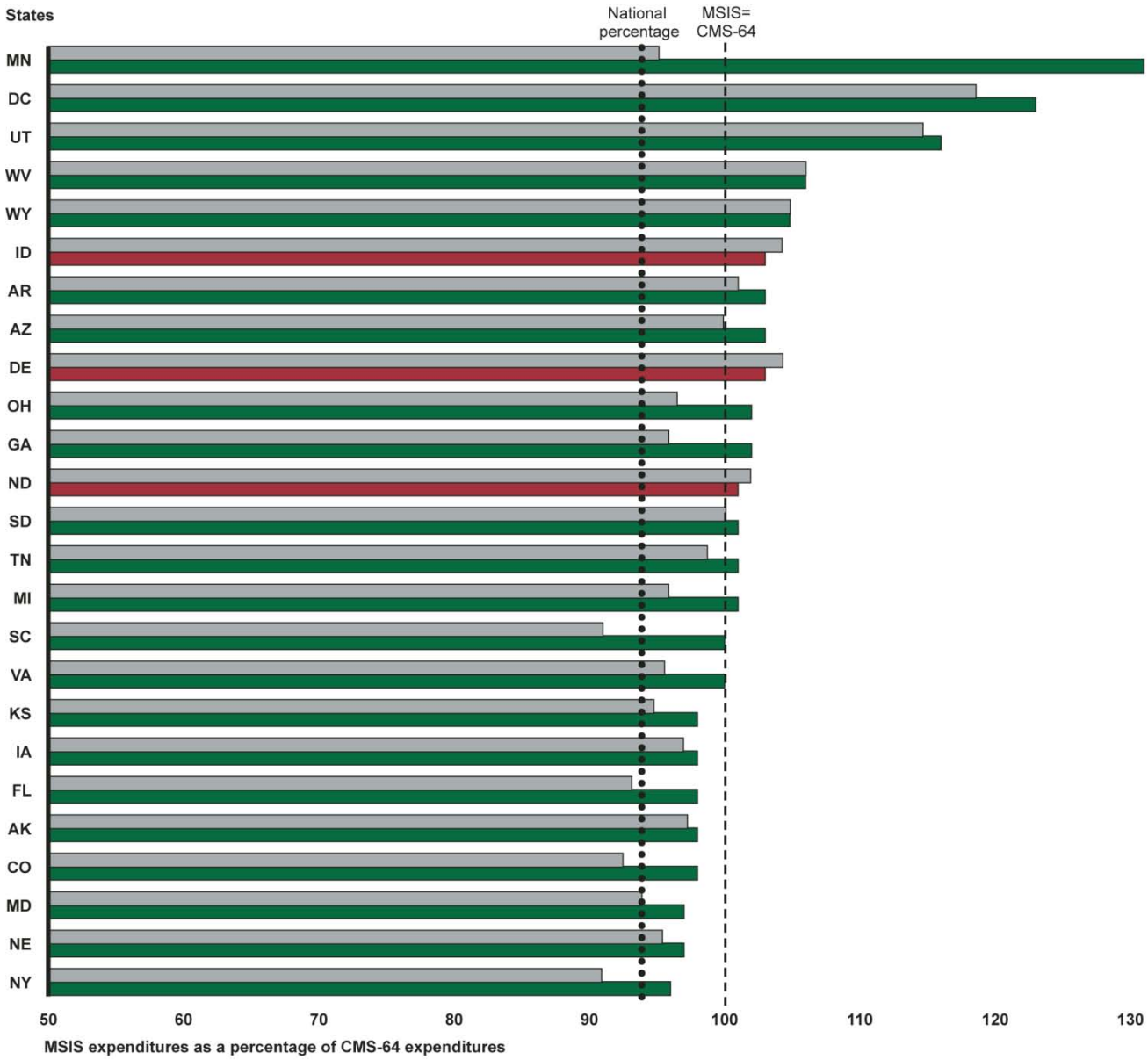


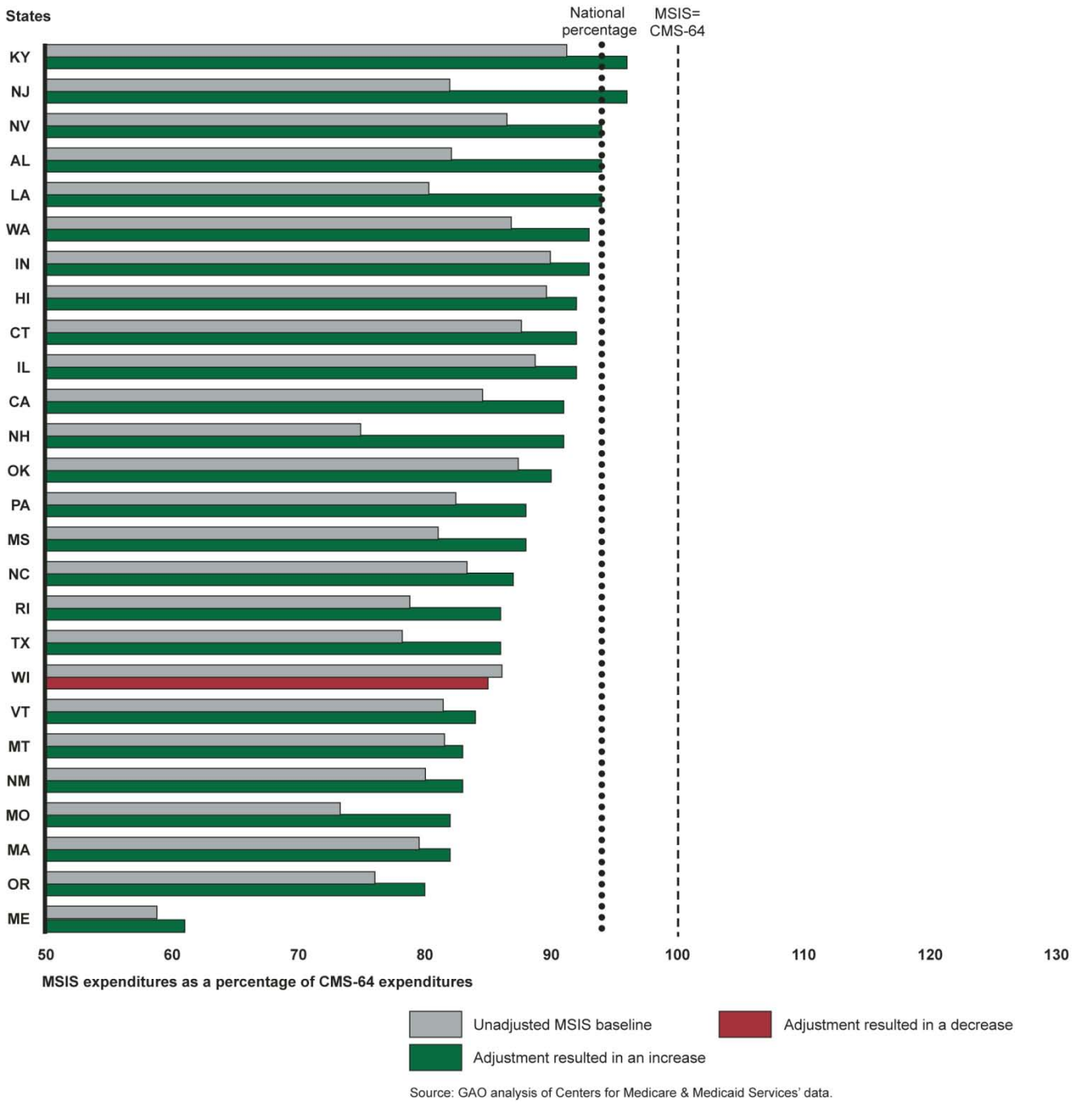
Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

[a]Adjustments were made by including reported CMS-64 dollars in the Medicaid Statistical Information Systems (MSIS).

After adjustments, MSIS Medicaid expenditures for individual states increased slightly, but generally remained less than CMS-64 amounts. For individual states, Medicaid expenditures in MSIS ranged from 55 percent to 131 percent of CMS-64 in fiscal years 2007 through 2009 after adjustments were made. For fiscal year 2009, 29 states reported lower expenditures in MSIS than in CMS-64, 9 states reported higher expenditures in MSIS than in CMS-64, and 13 states reported similar Medicaid expenditures in MSIS when compared with CMS-64. (See fig. 6.) See appendix III for a table of adjusted state expenditures reported in MSIS and CMS-64, by dollar amount, for fiscal year 2009. See appendix IV for a map showing the percentages of adjusted Medicaid expenditures in MSIS compared with CMS-64, by state, for fiscal year 2009.

Figure 6: Comparison of MSIS Baseline to Adjusted Medicaid Expenditures, as a Percentage of CMS-64, by State, Fiscal Year 2009



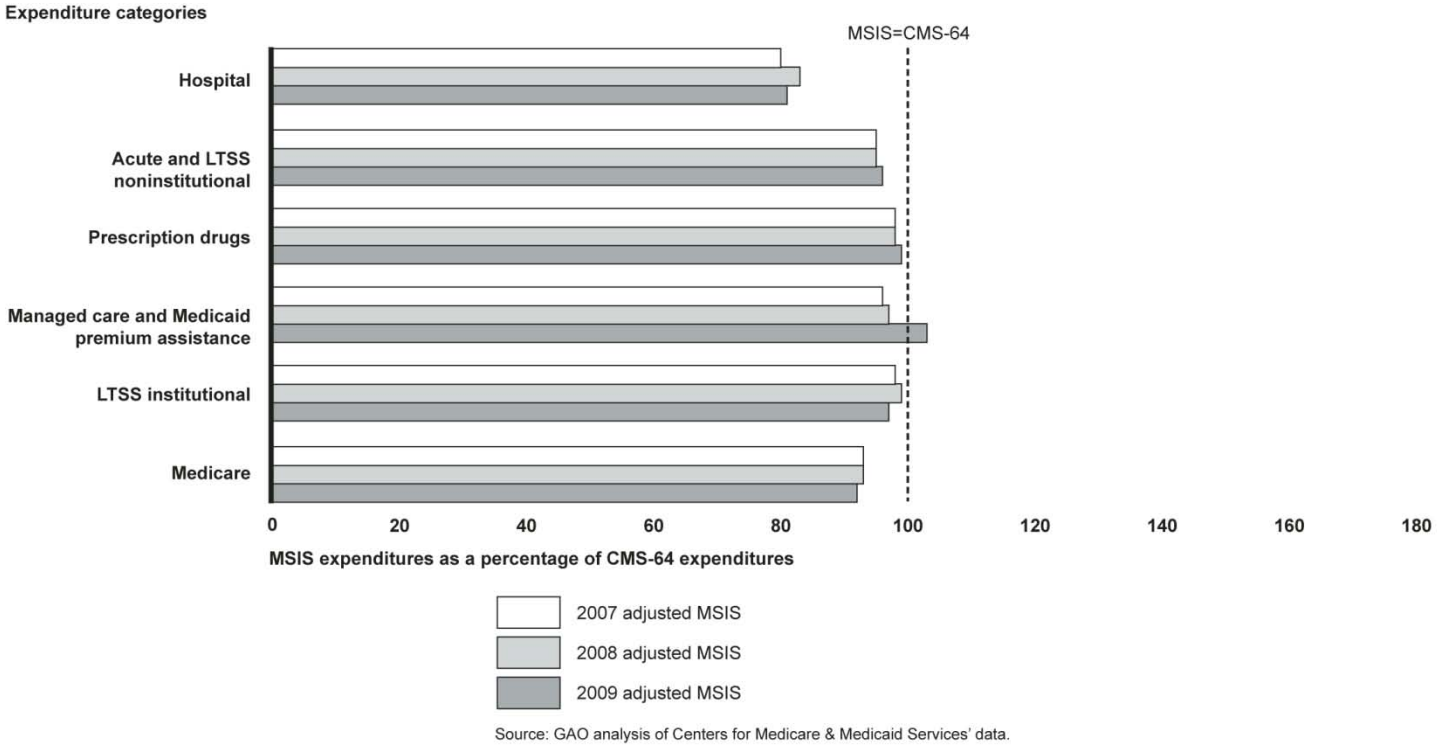


Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: Adjustments were made by including reported CMS-64 dollars in the Medicaid Statistical Information System (MSIS).

Differences between MSIS and CMS-64 Medicaid expenditures in six expenditure categories were also reduced after we adjusted the data in fiscal years 2007 through 2009. Two of the six expenditure categories—hospital and Medicare—continued to show the largest percentage difference in Medicaid expenditures between MSIS and CMS-64 data. After adjustments were made, MSIS Medicaid expenditures in the hospital category were 80, 83, and 81 percent of the amounts shown in CMS-64, respectively for fiscal years 2007, 2008, and 2009, compared with 61, 62, and 60 percent before the adjustments were made. Expenditures for Medicare increased from 0 percent to more than 90 percent for all 3 fiscal years when adjustments were made for Medicare premiums. (See fig. 7.)

Figure 7: Adjusted Medicaid Expenditures in MSIS as a Percentage of CMS-64, by Expenditure Category, Fiscal Years 2007–2009



Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: Adjustments were made by including reported CMS-64 dollars in the Medicaid Statistical Information System (MSIS). No adjustments were made for acute and long-term support services (LTSS)-noninstitutional and LTSS-institutional.

Inconsistent Guidance and States' Practices Result in Differences That Could Not Be Quantified

Inconsistent CMS guidance and states' practices resulted in differences between MSIS and CMS-64 data. However, we could not adjust for these factors because we could not quantify the extent to which these factors resulted in differences.

Three of the factors that account for the differences in expenditures result from inconsistent CMS guidance regarding expenditure definitions, reporting dates, and reporting supplemental payments during fiscal years 2007 through 2009.

- Inconsistent MSIS and CMS-64 Definitions: CMS guidance to states for reporting expenditures in MSIS and CMS-64 contained inconsistent definitions of services, making it impossible to do a one-for-one match of similar expenditures.[30] CMS officials indicated that the definitions used in guidance to states on completing the CMS-64 are based on definitions included in federal regulations,[31] while MSIS definitions are based on separate CMS guidance that was not derived from the regulations. These definitions are sometimes inconsistent. CMS officials explained that, for example, expenditures for inpatient services, as reported by a state in CMS-64, cannot be assumed to be the same services reported by the state in MSIS, despite the service having the same name in both data sets. Therefore, expenditures can be measured and reported by a state inconsistently across the data sets, making comparisons problematic. Specifically, even after adjustments were made, 13 states reported hospital-related expenditures in MSIS that were 75 percent or less of what they reported in their CMS-64 data.

  Additionally, inconsistent definitions across the two data sets make it difficult to examine Medicaid spending. For example, states may vary in their interpretation of the definitions in MSIS and CMS-64 guidance, and this inconsistency creates a challenge for examining total expenditures by service nationally and across states. (See app. V for reported expenditures by service, for all 50 states and the District of Columbia in fiscal year 2009.)

- Reporting Dates Differed: CMS officials recognized that CMS guidance to states for reporting the date of expenditures and adjusting payments made in prior years is different between MSIS and CMS-64. MSIS expenditures were based on each claim's date of adjudication—the date the payment was approved—while CMS-64 expenditures were reported as of the date of payment. The two data sets also differ in how they adjust payments made in prior years, according to CMS officials. Adjustments in MSIS allow the state to show changes to net

[30]*MSIS Guidance*: The CMS *MSIS File Specifications and Data Dictionary* provides information, including definitions, for MSIS reporting. *CMS-64 Guidance*: The *Category of Service Line Definitions for the 64.9* provides information, including definitions, for CMS-64 reporting of net expenditures.

[31]In general, service type definitions used for reporting expenditures on the CMS-64 are derived from federal regulation. See 42 C.F.R. part 440. (2011).

totals for the year, no matter when the adjustment was reported into the data. In contrast, adjustments to CMS-64 were entered for the fiscal year in which they were identified and the original year was not modified. MSIS and CMS-64 expenditures, therefore, may vary by quarter and by fiscal year if the dates associated with an expenditure differ. Since MSIS and CMS-64 report expenditures using different dates, we cannot adjust for this difference in the data. CMS officials indicated their concerns with this inconsistency and noted that it makes comparing expenditure data between the two data sets difficult.

- Supplemental Payments: For CMS-64 data, CMS officials required states to report supplemental payments within the corresponding expenditure categories, because states were not required to report these expenditures separately.[32] However, CMS officials indicated states reported supplemental payments in MSIS as a lump sum, and therefore they were excluded from the MSIS annual person summary file used in our analysis.[33] Therefore, supplemental payments, excluding DSH payments, were reported inconsistently between the two data sets during fiscal years 2007 through 2009.[34] As such, MSIS expenditure data are likely to show a lower amount than CMS-64 for several Medicaid expenditure categories. GAO and others have reported concerns about supplemental payments over the last decade, including the use of supplemental payment arrangements to increase federal funding without a commensurate increase in state funding.[35] Absent improved reporting, CMS cannot adequately oversee states' use of supplemental payments.

Three additional factors that accounted for the differences in expenditures result from inconsistent practices among states. Specifically, states are inconsistent in MSIS compared with CMS-64 regarding the timeliness of

[32]CMS added several new lines to the form CMS-64 in fiscal year 2010, including lines for states to report supplemental payments within each category of care for several expenditure types.

[33]CMS officials indicated that, on a rare occasion, states may report supplemental payments at the individual claims level. Overall, states report few supplemental payments in MSIS.

[34]See GAO-12-694.

[35]See GAO-11-278.

MSIS data, the quality of MSIS data reported, and payments for local government providers during fiscal years 2007 through 2009.

- Timeliness of MSIS data: States often delay reporting MSIS data, but report CMS-64 expenditure data on time. CMS guidance requires states to report data in CMS-64 within 30 days of the end of the quarter and within 45 days for MSIS. However, states have often been late reporting MSIS data, with some states delaying reporting of MSIS data for as long as 3 years. For example, as of July 2012, 37 states had submitted their fiscal year 2010 MSIS data, even though CMS requirements would indicate that MSIS data for 2010, 2011, and the first two quarters of 2012 should have already been provided. Alternatively, states submit their expenditures by means of CMS-64 on time and have a strong incentive to do so promptly because CMS uses this information to reimburse states for the federal share of Medicaid expenses. In contrast, states have less incentive to submit MSIS data promptly because the data are not tied to their federal reimbursement, and MSIS data are not used in the daily operations of their Medicaid programs. CMS officials told us that states that delay reporting can have issues with both the timeliness and quality of their submissions. If states submit poor quality data, CMS may reject the submission, resulting in further delays.[36]

- MSIS Data Quality: MSIS expenditure data are considered less reliable when compared with CMS-64. CMS-64 is reviewed regularly by CMS officials and considered the most-reliable and most-comprehensive data on Medicaid expenditures. Alternatively, while CMS conducts routine quality checks on MSIS data, problems still remain. CMS publishes a report of anomalous MSIS claims—those that are not consistent with what is expected to be reported by the state.[37] On the basis of our interviews with state Medicaid officials, the quality of MSIS data, as indicated by an anomalous claim, may be an additional factor that accounts for the difference between MSIS and CMS-64 reported expenditures. For example, Medicaid officials in one state we interviewed told us that the state incorrectly reported Home &

[36]CMS officials indicated that some states have also not reported their data in prior years. Additionally, the MSIS delay did not affect our ability to analyze the data because we used the most-recent and most-complete data available, fiscal years 2007 through 2009.

[37]The MSIS State Data Characteristics/Anomalies Report identifies MSIS data that are not reconciled after quality checks are completed between CMS and the state.

Community-Based 1915(c) waivers payments in MSIS in fiscal year 2009, and therefore CMS noted this in the anomalies report.[38] As a result of this error, the state underreported its MSIS expenditures for Home & Community-Based services compared with those reported on CMS-64. Having more timely data could be a mechanism for helping identify anomalies between the two systems and correcting discrepancies earlier.

- Local Government Provider Payments: CMS officials indicated that states may report in MSIS the amount paid to the local government for the medical service reported on the claim. However, the local government provider may also receive payment from the local government through prior alternative arrangements, and thus would not link these expenditures to a specific service provided or even report them at all in MSIS. These expenditures arise when states and localities finance Medicaid services through certified public expenditures.[39] In contrast, these additional expenditures would be captured in the total expenditures reported by states in CMS-64. Consequently, states may report a smaller amount in MSIS associated with the claim than reported by the state in total Medicaid expenditures on CMS-64. CMS officials indicated that neither CMS-64 nor MSIS provides a link to expenditures from government providers; as a result, we were unable to adjust for this difference.

CMS has indicated plans to improve MSIS through a pilot program called Transformed-MSIS. There are a number of goals for this pilot, including plans to establish MSIS as a robust, flexible, and repeatable data-collection process, to collect valid, timely information for decision making, and to integrate data between management information systems. These goals include a link between states' reporting of MSIS with reporting of CMS-64 data. However, CMS officials have indicated that there is no

[38]The 1915(c) waivers are one of many options available to states to allow the provision of long-term care services in home and community-based settings under the Medicaid program. States' programs can offer a combination of standard medical services, and nonmedical services, including homemaker, home health aide, personal care, adult day health services, habilitation, and respite care. See Social Security Act §1915(c), codified at 42 U.S.C. § 1396n(c).

[39]Under a Certified Public Expenditure arrangement, a government provider, such as a county hospital, certifies to a state the amount of expenditures for a Medicaid-covered service provided to a Medicaid beneficiary. The state obtains federal Medicaid matching funds based on the amount of the expenditure.

timeline for implementing this goal, whereas other aspects of the initiative are expected to be implemented in all states by fiscal year 2014. Moreover, such integration will only be of value if improvements are made in the timeliness and quality of MSIS data. One state in the pilot indicated that data-quality issues remain prevalent. Additionally, this state noted that the size and complexity of MSIS creates challenges with submissions' timeliness and availability. As of June 2012, CMS officials indicated that the initial results for the pilot program are being considered by management, yet until these plans have been fully implemented it is unclear what the outcome of these efforts will be.

Concluding Observations

In fiscal year 2009, the difference between MSIS and CMS-64 was $43 billion. Much of the difference was primarily the result of the different designs of each data set. CMS uses MSIS data for beneficiary-specific expenditures, while CMS-64 data are used to compute the federal financial participation for each state's Medicaid program costs. However, even after adjusting for DSH payments, Medicare premiums, prescription drug rebates, and Medicaid health insurance payments, differences remain. In fiscal year 2009, total MSIS expenditure data, after adjustments, showed MSIS at 94 percent of CMS-64 expenditures, which left billions of dollars unexplained.

The remaining differences between the two data sets are potentially explained by inconsistencies in CMS guidance and states' reporting practices, neither of which can be quantified. In fiscal years 2007 through 2009, CMS provided states with inconsistent MSIS and CMS-64 guidance regarding expenditure definitions, reporting dates, and reporting of supplemental payments. Additionally, when compared with CMS-64, state MSIS data were often delayed beyond the time frames established by CMS, inconsistent in reporting payments for local government providers, and were of poor quality.

Taken together, these two data sets have the potential to offer a robust view of the Medicaid program, enhancing CMS oversight of aggregate spending trends, per beneficiary spending growth, and cross-state comparisons, all of which could be useful in improving the financial integrity of this high-risk program. This is critical given that Medicaid, a program that GAO identified on our high-risk list, has among the highest estimated improper payments of any federal program reporting such data. However, the usefulness of these data sets as oversight tools is limited because of delays in reporting and unnecessary inconsistencies between the two data sets, both of which are inconsistent with federal internal

control standards. The 3-year lag in states' reporting of MSIS data prevents its use for timely oversight of beneficiary-related utilization and other spending trends. For example, identifying a difference in hospital expenditures between MSIS and CMS-64 is of limited use when detected 3 years later. If states were meeting the current requirement of providing MSIS data 45 days after each quarter, then such comparisons could provide more useful and timely information.

CMS has recently completed a pilot study aimed in part on improving MSIS data. CMS has indicated that it will begin implementing aspects of this initiative in all states by fiscal year 2014. One goal of this initiative is to integrate state reporting of MSIS with the reporting of CMS-64 data. However, CMS officials have indicated they have yet to determine a timeline for this goal. While the initial results of this pilot have not been finalized, improving the timeliness and consistency of MSIS and CMS-64 data through this effort could aid CMS's understanding and oversight of this high-risk program.

Agency Comments

HHS reviewed a draft of this report and provided technical comments, which we incorporated as appropriate.

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 of this report to the Secretary of Health and Human Services, the Administrator of CMS, 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 may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.

Sincerely yours,

Carolyn L. Yocom
Director, Health Care

Appendix I: Scope and Methodology

We conducted two types of analysis of Medicaid expenditures for this report to compare the Medicaid Statistical Information System (MSIS) and CMS-64 data. First, we conducted a baseline analysis to compare total expenditures reported to MSIS and CMS-64 nationally and by state. We also compared reported expenditures by expenditure category. Secondly, we conducted an adjustment analysis. Specifically, we attempted to reconcile the expenditures by making adjustments to MSIS on the basis of the differences we identified in the MSIS and CMS-64 data sets. To the extent possible, we added expenditures reported in CMS-64, but not reported in MSIS, to total expenditures in MSIS.

I. Baseline Analysis

To determine the extent to which MSIS and CMS-64 data sets on Medicaid expenditures differ, nationally and by state,[1] for fiscal years 2007 through 2009, we conducted a multistep analysis.[2] With total expenditures from both data sets, we calculated the expenditures reported in MSIS as a percentage of those reported in CMS-64. We also determined the percentage difference in total expenditures between the two data sets, by expenditure category.

Step 1: Obtain MSIS and CMS-64 Data

In order to identify the baseline of total Medicaid expenditures for fiscal years 2007 through 2009, we obtained from the Center for Medicare & Medicaid Services (CMS) MSIS and CMS-64 data for each of the 50 states and the District of Columbia.[3]

[1]In this report, we use the term "state" to refer to the 50 states and the District of Columbia. We do not include Puerto Rico or the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, or the U.S. Virgin Islands (which have Medicaid programs), Medicaid administrative expenses, or state collections in the CMS-64 because they were not reported in MSIS during fiscal years 2007 through 2009.

[2]We used these fiscal years because they were the most-recent and most-complete data available at the time of our analysis.

[3]We define the baseline to be our initial calculations of total Medicaid expenditures as reported by CMS-64 and MSIS for all 50 states and the District of Columbia. Therefore, the baseline does not include any adjustments to the data. There is a baseline expenditure amount for CMS-64 and another for MSIS. Additionally, U.S. territories were excluded from our analysis because they do not report any Medicaid claims in MSIS.

- *MSIS data*: We obtained the MSIS Annual Person Summary File data, which CMS officials confirmed were appropriate for our analysis. The summary file includes monthly enrollment data, but only includes annual expenditure data by type of service.[4] It is most comparable to CMS-64 because both data sets provide total expenditures for the fiscal year. The summary file also includes some enrollment and expenditure information on the Children's Health Insurance Program (CHIP).[5]

- *CMS-64 data*: We used the CMS-64 net expenditures financial management report within the Medicaid Budget and Expenditure System. The financial management report is an annual account of states' program and administrative Medicaid expenditures, including federal and state expenditures by expenditure category. The financial management report also contains information solely related to Medicaid.

Step 2: Determine Medicaid Expenditures in MSIS for the Fiscal Year on the Basis of the Number of Medicaid Enrollees

Because MSIS includes both Medicaid and CHIP expenditures, we separated these expenditures to the extent possible. To do this, we first determined whether a beneficiary was eligible for Medicaid or CHIP by using the monthly eligibility code in MSIS.[6] The Annual Person Summary File ties an entire month's expenditures to an individual on the basis of his

[4]MSIS includes some lump sum expenditures that are not captured using the annual person summary file.

[5]MSIS data are available in several file formats, including (1) full files with detailed claims and enrollment data by individual, such as encounters, name of provider, and type of care as reported directly by the states; (2) annual person summary files of expenditure data, which summarize all the data for a person for the fiscal year, but exclude some encounter details included in the full file (for example, the summary file may not include details regarding the care encounter, such as individual cost per encounter; however, it does include monthly enrollment data); (3) Medicaid Analytic eXtract (MAX) files, which are considered to have the highest-quality data, but also have the greatest delay in availability—up to 3 years; and (4) the State Summary DataMart, which is a public online data system that provides state aggregated Medicaid claims, but not by the individual person.

[6]The monthly eligibility categories include both Medicaid and CHIP. The eligibility categories and their MSIS coding are: 0=ineligible, 1=Medicaid, 2=Medicaid Expansion CHIP (M-CHIP), 3=CHIP non-Medicaid (also known as S-CHIP), and 4=CHIP unknown (also interpreted to mean that the eligibility overall is unknown).

or her monthly eligibility code. The next step was to remove, to the extent possible, the CHIP expenditures in order to match MSIS expenditures with CMS-64. (CMS-64 does not include CHIP expenditures.)

CMS officials indicated that states were able to report CHIP expenditures within MSIS if they had a Medicaid expansion-CHIP program (i.e., a CHIP program that operates as part of the Medicaid program), also known as M-CHIP.[7] Consequently, we were able to distinguish between Medicaid and M-CHIP spending.[8] We thus removed from all MSIS totals any M-CHIP expenditures to the extent possible. We determined the number of months in the fiscal year a beneficiary received benefits under Medicaid or M-CHIP. On the basis of this count, we prorated the enrollees' total expenses for the fiscal year on the basis of the proportion of the year a person was enrolled in either M-CHIP or Medicaid. If a person was enrolled in the M-CHIP program for part of the year, then a portion of the annual spending was apportioned toward M-CHIP. For example, if a person was enrolled in M-CHIP for 3 months, then a quarter of the expenditures would be considered M-CHIP, and the remaining three-quarters of expenditures would be considered Medicaid. Consequently, the Medicaid expenditures include prorated amounts for Medicaid and M-CHIP enrollees.

In contrast, CMS officials told us that until fiscal year 2010, states with a stand-alone CHIP program (i.e., one that is operated separately from a Medicaid program by the state; also known as S-CHIP) were not supposed to report these expenditures into MSIS despite the presence of the S-CHIP eligibility code. CMS officials indicated that any expenditures associated with S-CHIP should be assumed to be Medicaid expenditures despite the CHIP eligibility code. Therefore, we included any expenditures associated with the S-CHIP code as Medicaid expenditures.[9]

[7]Instead of a M-CHIP program, a state may elect to have a stand-alone CHIP program that is operated separately from the Medicaid program. Stand-alone programs are referred to as S-CHIP.

[8]Although M-CHIP programs operate as expansions of Medicaid programs, expenditures are considered CHIP expenditures rather than Medicaid expenditures.

[9]Expenditures in MSIS for enrollees whose eligibility was listed as S-CHIP totaled $481 million in fiscal year 2009, or less than 1 percent of total Medicaid expenditures reported in MSIS.

Lastly, we included as Medicaid expenditures any other expenditures associated with all other eligibility categories. These other eligibility variables included "unknown" and "ineligible," as well as Medicaid.[10] Consequently, for states with standalone S-CHIP programs and those that did not separate out M-CHIP expenditures, the total Medicaid expenditures may be inflated in MSIS. Similarly, any expenditures reported under the unknown and ineligible categories that were not Medicaid expenditures may also inflate Medicaid expenditures.

Step 3: Matching Inconsistent Definitions of Services between MSIS and CMS-64

MSIS and CMS-64 data consist of expenditures broken down by service types.[11] To compare MSIS and CMS-64 expenditures, we reviewed the definitions of Medicaid service types used in each data set. This is necessary because, in many instances, a one-to-one match of service types in MSIS to those in CMS-64 is not possible. For example, in fiscal years 2007 through 2009, the MSIS Annual Person Summary File had 29 service types, whereas CMS-64 had 43. (See table 3 for a list of MSIS and CMS-64 service types used in fiscal years 2007 through 2009.)

[10]Expenditures in MSIS for enrollees whose eligibility was listed as unknown or ineligible totaled approximately $28 billion and $6 billion, respectively, in fiscal year 2009; or approximately 9 percent and 2 percent of total Medicaid expenditures reported in MSIS.

[11]While we are matching services between these two data sets, some of the expenditures we describe here are not directly tied to a Medicaid service in MSIS, such as Medicaid payments for Medicare premiums.

Table 3: Medicaid Statistical Information System (MSIS) and CMS-64 Service Types, Fiscal Years 2007–2009

MSIS service types	CMS-64 line numbers and service types
Inpatient hospital	1A. Inpatient hospital
Inpatient mental health–aged	1B. Inpatient hospital–DSH
Inpatient mental health–under 21	2A. Mental health facility
Intermediate care facility–mentally retarded	2B. Mental health facility–DSH
Nursing facility	3. Nursing facility services
Physician	4A. Intermediate care facility–mentally retarded (public providers)
Dental	4B. Intermediate care facility–mentally retarded (private providers)
Other practitioner	5. Physicians services
Outpatient hospital	6. Outpatient hospital services
Clinic	7. Prescribed drugs (gross spending)
Home health	7A1. Drug rebates offset (national agreement)
Lab and x-ray	7A2. Drug rebates offset (state sidebar agreement)
Drugs	8. Dental
Other services	9. Other practitioner services
HMO-capitation	10. Clinic services
Prepaid Health Plan (PHP)–capitation	11. Laboratory and radiological services
Primary Care Case Management (PCCM)–capitation	12. Home health services
Sterilization	13. Sterilizations
Abortion	14. Abortions
Transportation	15. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services
Personal care	16. Rural health clinic screenings
Targeted case management	17A. Medicare health insurance payments–Part A premiums
Rehabilitative services	17B. Medicare health insurance payments–Part B premiums
Physical, occupational, speech, and hearing therapy	17C1. 120 percent–134 percent of the poverty level[a]
Hospice	17C2. 135 percent–175 percent of the poverty level[b]
Nurse Midwife	17D. Medicare–coinsurance and deductibles
Nurse Practitioner	18A. Medicaid health insurance payments–managed care organizations
Private duty nurse	18B1. Medicaid health insurance payments–prepaid ambulatory health plan
Unknown	18B2. Medicaid health insurance payments–prepaid inpatient health plan
	18C. Medicaid health insurance payments–group health plan payments
	18D. Medicaid health insurance payments–coinsurance and deductibles
	18E. Medicaid health insurance payments–other
	19. Home and community based services
	20. Home and community based care for functionally disabled elderly
	21. Community supported living services

MSIS service types	CMS-64 line numbers and service types
	22. Programs of All-Inclusive Care for the Elderly (PACE)
	23. Personal care services
	24. Targeted case management services
	25. Primary Care Case Management (PCCM) Services
	26. Hospice benefits
	27. Emergency services for undocumented aliens
	28. Federally-qualified health center
	29. Other care services

Source: GAO analysis of Centers for Medicare & Medicaid Services data.

[a]Medicaid expenditures reported on line 17C1 include premiums paid for Medicare Part B for individuals whose income is 120-134 percent of the poverty level.

[b]Medicaid expenditures reported on line 17C2 include the percentage of the Medicare Part B premium attributable to the Home Health Benefit transferred from Part A to Part B for individuals whose income is 135-175 percent of the poverty level.

Because of the lack of a one-to-one match between MSIS and CMS-64 service types, we combined MSIS and CMS-64 service types into six combined expenditure categories. (See table 4 for the list of the combined expenditure categories, and MSIS and CMS-64 service types included in each.) As a result, we were able to report on total expenditures by combined expenditure categories.

Table 4: Combined Expenditure Categories and Corresponding MSIS and CMS-64 Service Types

Combined expenditure categories	MSIS service types	CMS-64 line numbers and service types	
Hospital	Inpatient hospital Outpatient hospital Inpatient mental health facility for under age 21 Mental health facility for the aged	1A.	Inpatient hospital
		1B.	Inpatient hospital–Disproportionate Share Hospitals (DSH)
		2A.	Mental health facility
		2B.	Mental health facility–DSH
		6.	Outpatient hospital services
		27.	Emergency services for undocumented aliens
Acute and long term support services (LTSS)-noninstitutional	Physician Dental Nurse midwife Nurse practitioner Other practitioner Home health Clinic Lab and x-ray Sterilizations Abortions Personal care Private duty nursing Targeted case management Rehabilitative services Hospice Other services Physical, occupational, speech, and hearing therapy Transportation services	5.	Physicians services
		8.	Dental
		9.	Other practitioner services
		10.	Clinic services
		11.	Laboratory and radiological services
		12.	Home health services
		13.	Sterilizations
		14.	Abortions
		15.	Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
		16.	Rural health clinic screenings
		19.	Home and community based services
		20.	Home and community based care for functionally disabled elderly
		21.	Community supported living services
		23.	Personal care services
		24.	Targeted case management services
		26.	Hospice benefits
		28.	Federally Qualified Health Center (FQHC)
		29.	Other care services
Drugs	Drugs (gross spending)	7.	Prescribed drugs (gross spending)
		7A1.	Drug rebates offset (national agreement)
		7A2.	Drug rebates offset (state sidebar agreement)

Combined expenditure categories	MSIS service types	CMS-64 line numbers and service types
Managed care and Medicaid premium assistance	HMO capitation Prepaid Health Plan (PHP) Primary care case management	18A. Medicaid health insurance payments–managed care organizations
		18B1. Medicaid health insurance payments–Prepaid Ambulatory Health Plan
		18B2. Medicaid health insurance payments–Prepaid Inpatient Health Plan
		18C. Medicaid health insurance payments–Group Health Plan Payments
		18D. Medicaid health insurance payments–Coinsurance and Deductibles
		18E. Medicaid health insurance payments–other
		25. Primary Care Case Management (PCCM) Services
		22. Program of All-Inclusive Care for the Elderly (PACE)
Long term support services-institutional	Nursing facility Intermediate care facility–mentally retarded	3. Nursing facility services
		4A. Intermediate care facility-mentally retarded (public providers)
		4B. Intermediate care facility-mentally retarded (private providers)
Medicare		17A. Medicare health insurance payments–Part A premiums
		17B. Medicare health insurance payments–Part B premiums
		17C1. 120–134 percent of the poverty level
		17C2. 135–175 percent of the poverty level
		17D. Medicare coinsurance and deductibles

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data.

Notes: The combined expenditure categories listed are based on analysis of the Medicaid Statistical Information System (MSIS) and CMS service types. We combined acute care and long term support services because CMS officials told us there was overlap between services in each type of care.

The MSIS "unknown" service type was proportionally distributed across 5 categories, excluding Medicare.

While states could report expenditures under "Religious non-medical" in CMS-64 for fiscal years 2007 through 2009, no state did so. There is no corresponding category in MSIS.

Step 4: Excluded Expenditures

For certain CMS-64 expenditures, instead of adding them to MSIS, we excluded them from CMS-64. Specifically, expenditures from Puerto Rico or the U.S. territories from CMS-64 were excluded because these are not in MSIS data.

Additionally, we excluded all administrative expenses from CMS-64 reported amounts, because these are not reported in MSIS data. We also excluded all state collections from CMS-64, because these are not in MSIS.[12]

Step 5: Comparison of MSIS and CMS-64 Expenditures

We compared total Medicaid expenditures in MSIS and CMS-64 for fiscal years 2007 through 2009, nationally and for all 50 states and the District of Columbia, to determine the extent of the difference between these two data sets. With total expenditures from both data sets, we calculated the expenditures in MSIS as a percentage of those reported in CMS-64. We also compared total Medicaid expenditures by our six combined expenditure categories, as reported by MSIS and CMS-64 for fiscal years 2007 through 2009.

II. Adjustment Analysis

To conduct our adjustment analysis, we determined the factors that account for the difference between MSIS and CMS-64 data on Medicaid expenditures. We identified and analyzed factors that account for the differences in each data set in fiscal years 2007 through 2009. We attempted to reconcile the expenditures by making adjustments to the MSIS expenditures on the basis of the differences we identified. In attempting to reconcile these differences, we made adjustments to the baseline analysis described above. Specifically, we added expenditures reported in CMS-64 that were not reported in MSIS to the MSIS amounts. We added expenditures to MSIS rather than subtracting them from CMS-64, because CMS-64 contains total Medicaid spending, and the additions make MSIS a better approximation of this spending. For certain service types, MSIS and CMS-64 reported different amounts of Medicaid expenditures because of differences in the way they capture the expenditure information. We identified four factors that account for the differences that we were able to quantify. Therefore, we adjusted the MSIS baseline amount and reduced the gap between the two data sets. Specifically, MSIS does not include Disproportionate Share Hospital (DSH) payments, Medicare premiums, prescription drug rebates, and

[12]State collections include offsetting collections from third-party liability, estate, and other recoveries.

Medicaid health insurance payments. We then compared total adjusted expenditures nationally and by state. We did this by comparing the expenditures reported in MSIS as a percentage of those reported in CMS-64. We also compared adjusted expenditures by combined expenditure category, nationally and by state.

Step 1:

We added expenditures from DSH payments as reported on line 1B (Inpatient Hospital Service–DSH Adjustment Payments) in CMS-64 to the MSIS baseline amount within the Combined Hospital expenditure category.

Step 2:

We added expenditures related to Medicare premiums from lines 17A (Medicare Health Insurance Payments–Part A premiums), 17B (Medicare Health Insurance Payments–Part B premiums), 17C1 (120–134 percent of the poverty level), and 17C2 (135–175 percent of the poverty level) from CMS-64 to the MSIS baseline amount within the combined Medicare expenditure category.[13]

Step 3:

We subtracted prescription drug rebate amounts reported on line 7A1 (Drug Rebate Offset–National Agreement) and 7A2 (Drug Rebate Offset–State Sidebar Agreement) in CMS-64 within the prescription drugs expenditure category from the MSIS baseline amount within the Combined Prescription Drug expenditure category.[14]

[13]Medicaid expenditures reported on line 17C1 include premiums paid for Medicare Part B for individuals whose income is 120–134 percent of the poverty level. Medicaid expenditures reported on line 17C2 include the percentage of the Medicare Part B premium attributable to the Home Health Benefit transferred from Part A to Part B for individuals whose income is 135–175 percent of the poverty level.

[14]Unlike the other adjustments, the adjustment for prescription drug rebates decreases the spending reported in MSIS. Prescription drug spending is overreported in MSIS because rebates are not included in the data set. Consequently, for this category we subtracted the amounted reported in CMS-64 for prescription drug rebates from the amount in MSIS.

Step 4:

We added expenditures related to Medicaid health insurance payments from lines 18C (Medicaid health insurance payments–Group Health Plan Payments), 18D (Medicaid health insurance payments–Coinsurance and Deductibles) and 18E (Medicaid health insurance payments–Other) in CMS 64 to the MSIS baseline amount within the combined managed care and Medicaid premium assistance category.

Step 5:

After making the adjustments in steps 1 through 4, we compared the total adjusted Medicaid expenditures as reported in MSIS and CMS-64 for fiscal years 2007 through 2009, nationally and for all 50 states and the District of Columbia. With total expenditures from both data sets, we calculated the expenditures reported in MSIS as a percentage of those reported in CMS-64.

We also compared total adjusted Medicaid expenditures by our six expenditure categories, as reported by MSIS and CMS-64 for fiscal years 2007 through 2009.

After making the expenditure adjustments, we determined any remaining expenditure differences between MSIS and CMS-64. We then identified additional factors that help account for the difference between data sets. However, because these were not systematic quantitative differences, they could not be used to adjust the expenditures.

We conducted this performance audit from March 2012 through September 2012 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.

Appendix II: Total Baseline Medicaid Expenditures in MSIS and CMS-64, by State, Fiscal Year 2009

State	MSIS baseline (dollars)	CMS-64 baseline (dollars)	MSIS baseline as a percent of CMS-64
Alabama	$3,625,540,937	$4,415,801,712	82%
Alaska	1,040,288,855	1,069,624,574	97
Arizona	8,628,093,458	8,665,269,493	100
Arkansas	3,486,489,877	3,451,516,646	101
California	35,002,258,860	41,389,559,881	85
Colorado	3,288,276,426	3,555,155,172	92
Connecticut	5,289,134,290	6,035,281,239	88
Delaware	1,263,983,534	1,211,814,329	104
District of Columbia	1,928,483,265	1,626,139,477	119
Florida	14,051,386,231	15,088,582,200	93
Georgia	7,376,411,423	7,693,345,212	96
Hawaii	1,172,582,338	1,308,211,194	90
Idaho	1,330,846,516	1,276,526,247	104
Illinois	11,658,850,516	13,140,383,274	89
Indiana	5,312,111,931	5,906,490,283	90
Iowa	2,870,172,181	2,960,114,156	97
Kansas	2,315,819,323	2,443,675,864	95
Kentucky	4,927,054,393	5,400,899,512	91
Louisiana	5,230,654,120	6,513,211,836	80
Maine	1,480,509,448	2,517,981,111	59
Maryland	6,124,798,441	6,523,939,093	94
Massachusetts	9,928,887,946	12,480,644,429	80
Michigan	10,145,744,904	10,583,215,243	96
Minnesota	7,029,437,421	7,387,421,506	95
Mississippi	3,199,788,959	3,947,805,053	81
Missouri	5,679,022,531	7,747,665,625	73
Montana	714,263,803	875,768,845	82
Nebraska	1,542,139,671	1,616,257,729	95
Nevada	1,196,285,725	1,383,003,611	86
New Hampshire	994,261,996	1,327,164,314	75
New Jersey	7,924,068,702	9,667,209,281	82
New Mexico	2,633,955,686	3,290,379,397	80
New York	44,882,629,782	49,368,510,253	91
North Carolina	9,589,597,797	11,506,119,180	83
North Dakota	581,137,250	572,101,389	102

State	MSIS baseline (dollars)	CMS-64 baseline (dollars)	MSIS baseline as a percent of CMS-64
Ohio	13,655,184,427	14,150,220,981	97
Oklahoma	3,441,451,894	3,937,604,747	87
Oregon	2,797,080,333	3,677,976,463	76
Pennsylvania	14,206,934,568	17,231,560,151	82
Rhode Island	1,492,164,387	1,893,290,969	79
South Carolina	4,640,158,035	5,098,527,910	91
South Dakota	716,509,192	713,353,957	100
Tennessee	7,197,427,171	7,290,231,215	99
Texas	18,542,742,821	23,704,821,993	78
Utah	1,867,632,519	1,628,633,714	115
Vermont	969,805,347	1,190,678,054	81
Virginia	5,518,557,224	5,774,994,043	96
Washington	5,733,929,571	6,603,087,308	87
West Virginia	2,588,751,602	2,434,058,051	106
Wisconsin	5,754,921,788	6,684,081,412	86
Wyoming	551,809,947	526,237,765	105
Total	**$323,120,029,363**	**$366,486,147,093**	**88%**

Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: MSIS = Medicaid Statistical Information System

Appendix III: Total Adjusted Medicaid Expenditures in MSIS and CMS-64, by State, Fiscal Year 2009

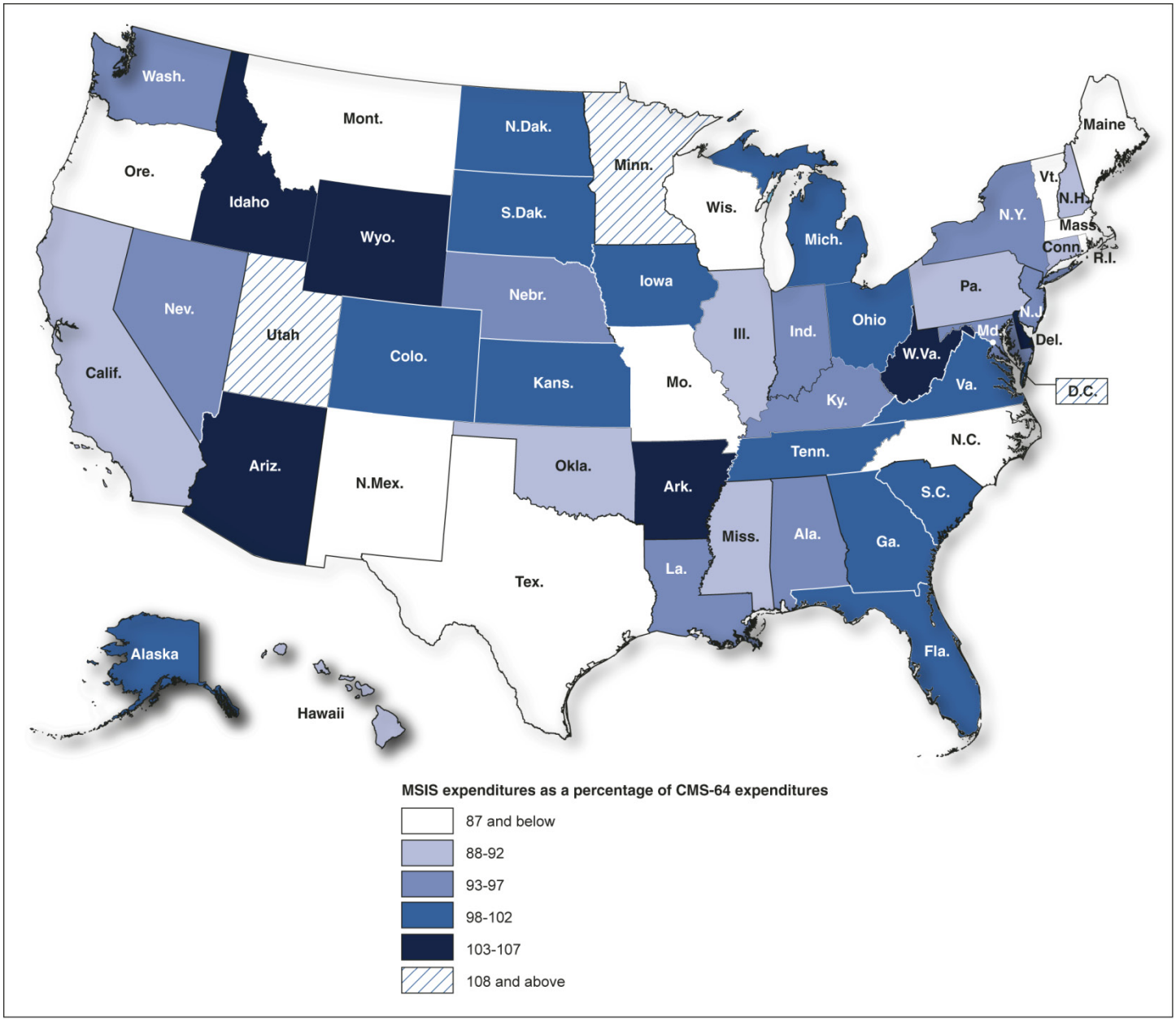
State	MSIS adjusted (dollars)	CMS-64 baseline (dollars)	MSIS adjusted as a percent of CMS-64
Alabama	$4,149,081,465	$4,415,801,712	94%
Alaska	1,044,650,976	1,069,624,574	98
Arizona	8,950,429,121	8,665,269,493	103
Arkansas	3,566,963,553	3,451,516,646	103
California	37,800,029,701	41,389,559,881	91
Colorado	3,469,734,861	3,555,155,172	98
Connecticut	5,565,391,332	6,035,281,239	92
Delaware	1,243,966,462	1,211,814,329	103
District of Columbia	1,998,599,795	1,626,139,477	123
Florida	14,754,686,816	15,088,582,200	98
Georgia	7,835,521,037	7,693,345,212	102
Hawaii	1,209,812,682	1,308,211,194	92
Idaho	1,320,590,808	1,276,526,247	103
Illinois	12,053,935,834	13,140,383,274	92
Indiana	5,488,175,214	5,906,490,283	93
Iowa	2,895,286,487	2,960,114,156	98
Kansas	2,391,474,252	2,443,675,864	98
Kentucky	5,170,171,436	5,400,899,512	96
Louisiana	6,117,964,332	6,513,211,836	94
Maine	1,530,105,787	2,517,981,111	61
Maryland	6,308,462,604	6,523,939,093	97
Massachusetts	10,223,698,086	12,480,644,429	82
Michigan	10,671,661,360	10,583,215,243	101
Minnesota	9,661,603,386	7,387,421,506	131
Mississippi	3,458,893,939	3,947,805,053	88
Missouri	6,348,322,455	7,747,665,625	82
Montana	730,414,065	875,768,845	83
Nebraska	1,559,900,885	1,616,257,729	97
Nevada	1,305,273,428	1,383,003,611	94
New Hampshire	1,210,132,665	1,327,164,314	91
New Jersey	9,240,294,628	9,667,209,281	96
New Mexico	2,720,776,943	3,290,379,397	83
New York	47,601,163,307	49,368,510,253	96
North Carolina	10,037,581,856	11,506,119,180	87
North Dakota	580,335,888	572,101,389	101

State	MSIS adjusted (dollars)	CMS-64 baseline (dollars)	MSIS adjusted as a percent of CMS-64
Ohio	14,470,087,279	14,150,220,981	102
Oklahoma	3,541,362,801	3,937,604,747	90
Oregon	2,950,571,584	3,677,976,463	80
Pennsylvania	15,215,057,372	17,231,560,151	88
Rhode Island	1,630,860,669	1,893,290,969	86
South Carolina	5,117,449,890	5,098,527,910	100
South Dakota	720,846,348	713,353,957	101
Tennessee	7,363,722,376	7,290,231,215	101
Texas	20,378,285,311	23,704,821,993	86
Utah	1,881,512,781	1,628,633,714	116
Vermont	1,000,491,043	1,190,678,054	84
Virginia	5,749,185,155	5,774,994,043	100
Washington	6,150,885,067	6,603,087,308	93
West Virginia	2,582,401,847	2,434,058,051	106
Wisconsin	5,653,921,737	6,684,081,412	85
Wyoming	550,456,264	526,237,765	105
Total	**$345,172,184,969**	**$366,486,147,093**	**94%**

Source: GAO analysis of Centers for Medicare & Medicaid Services' data.

Note: Adjustments were made by adding expenditures reported in CMS-64 to those reported in the Medicaid Statistical Information System (MSIS). Specifically, we added Disproportionate Share Hospital payments, national and state rebates for prescription drugs, Medicaid health insurance payments, and Medicare premiums to the expenditures reported in MSIS.

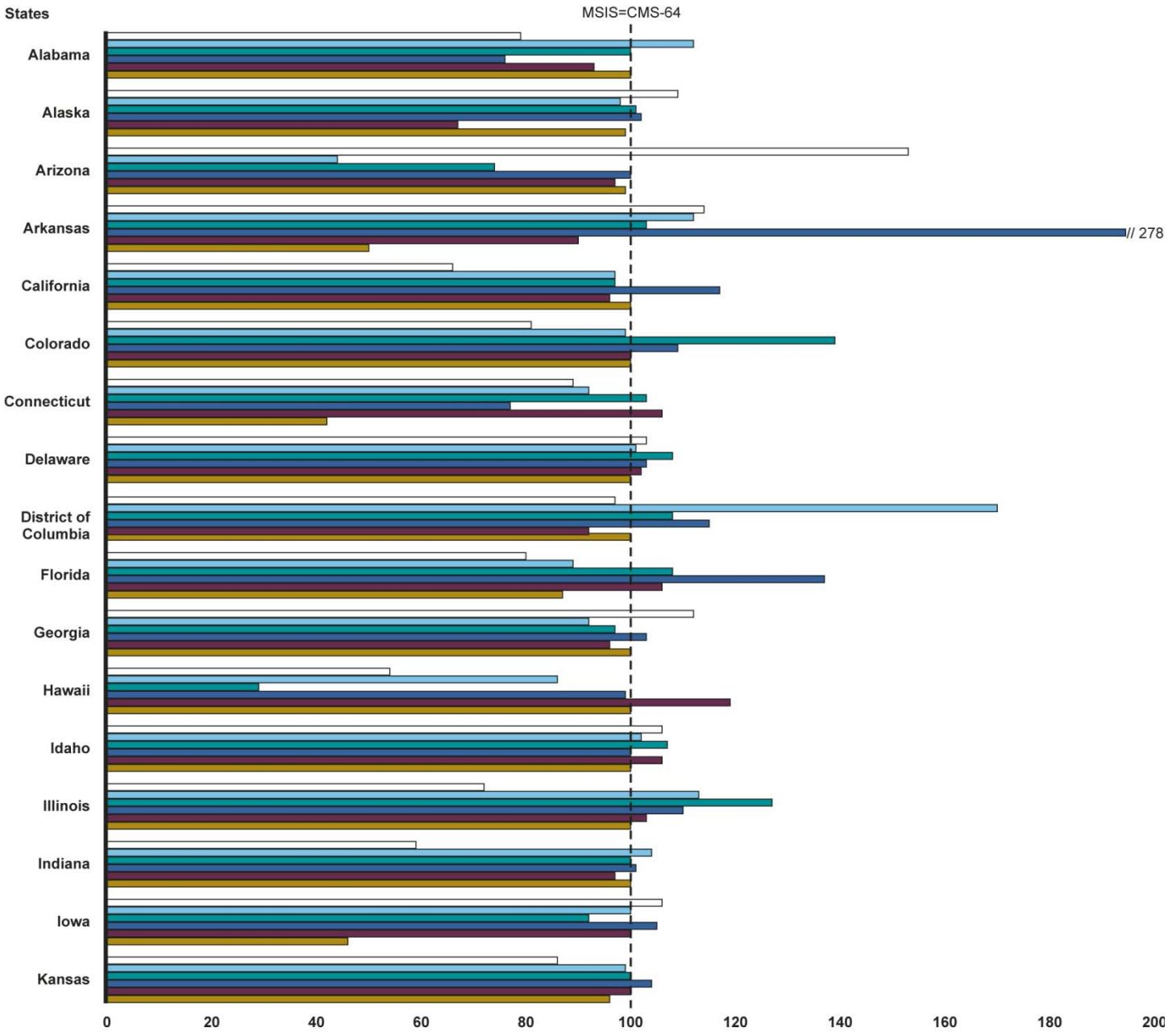
Appendix IV: Adjusted MSIS Expenditures as a Percentage of CMS-64, by State, Fiscal Year 2009

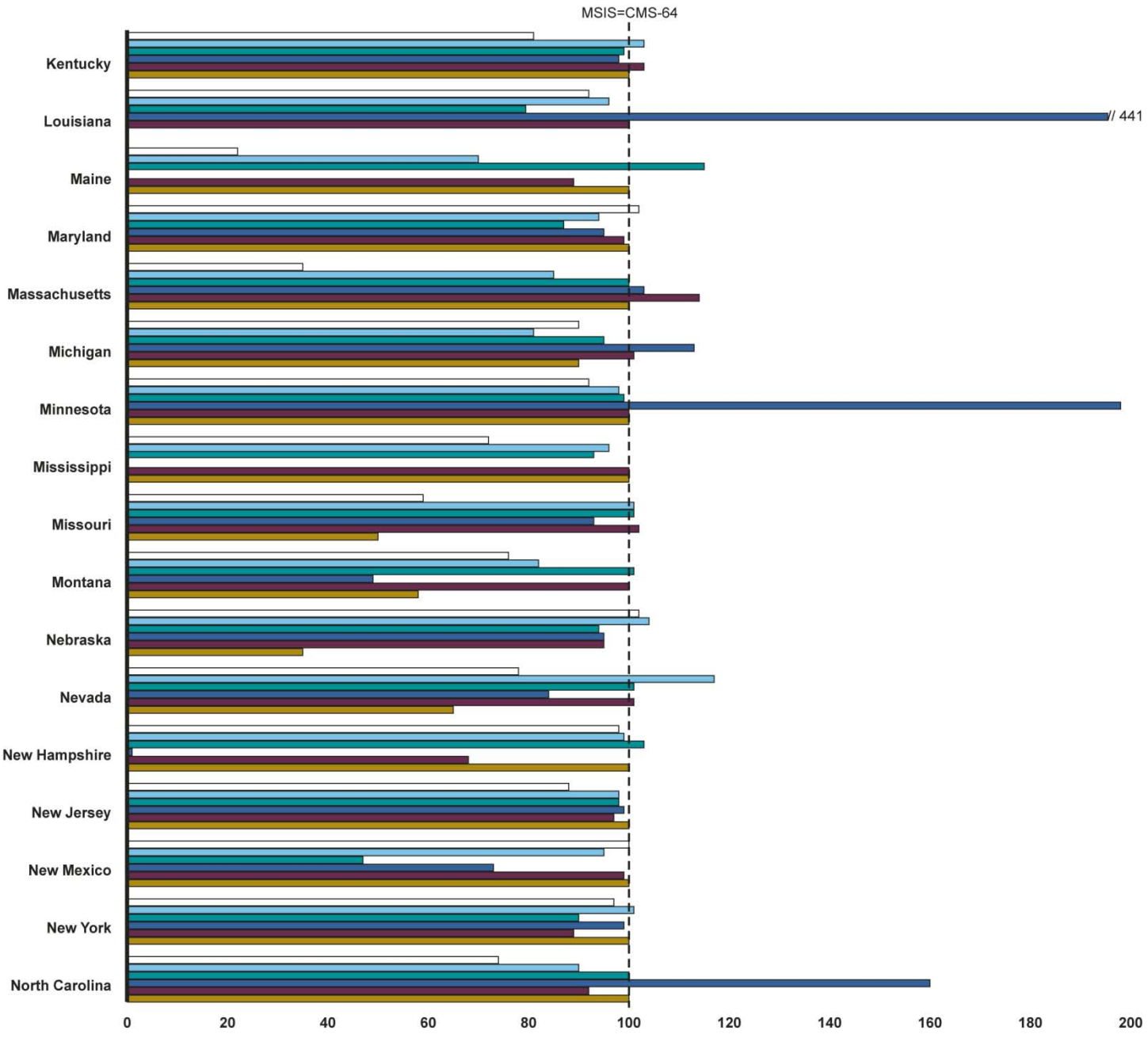


Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data; MapArt (map).

Note: Adjustments were made by adding expenditures reported in CMS-64 to those reported in the Medicaid Statistical Information System (MSIS). Specifically, we added Disproportionate Share Hospital payments, national and state rebates for prescription drugs, Medicaid health insurance payments, and Medicare premiums to the expenditures reported in MSIS.

Appendix V: Adjusted MSIS Expenditures as a Percentage of CMS-64, by State and Expenditure Category, Fiscal Year 2009




MSIS=CMS-64
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
// 441
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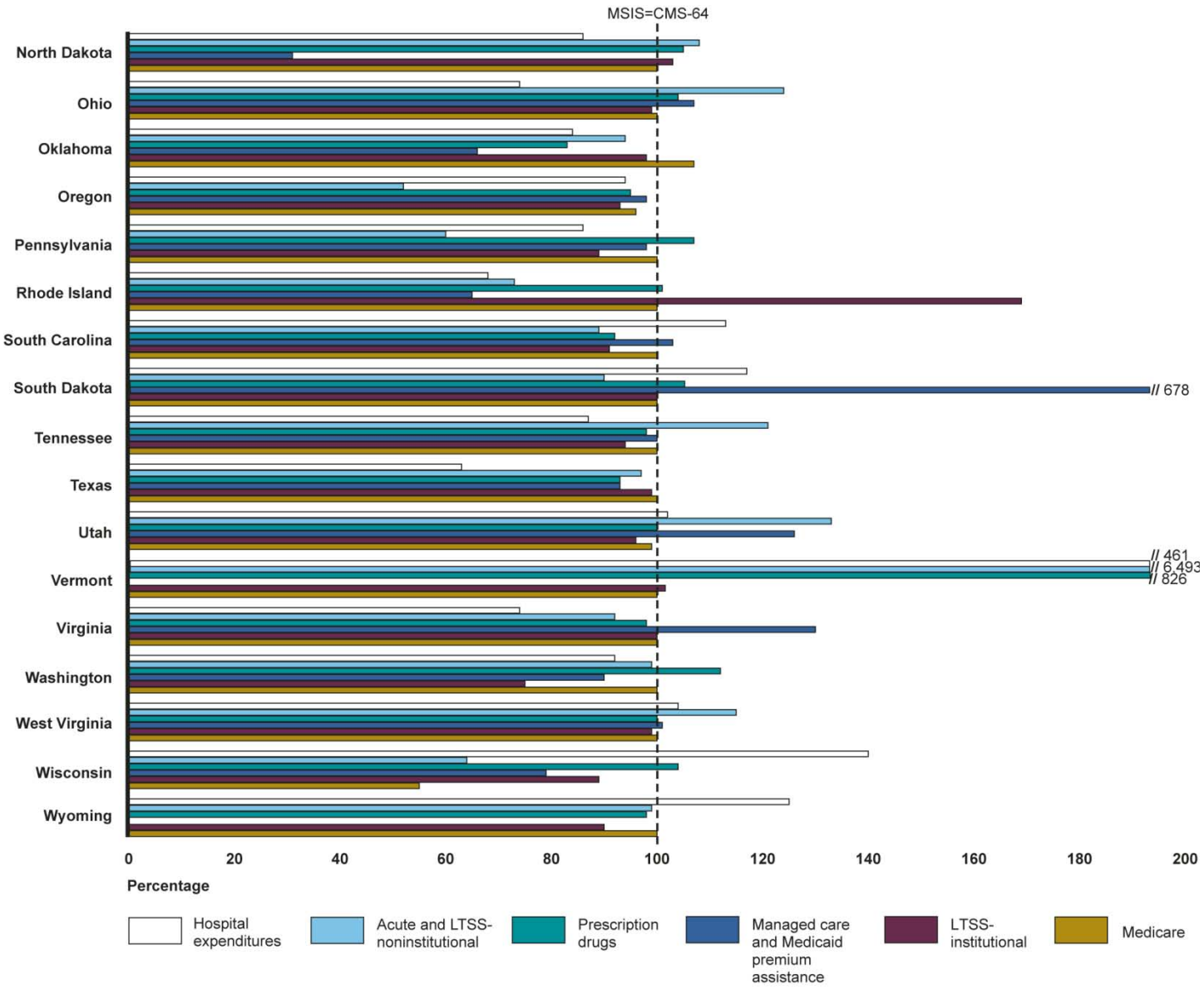
20
40
60
80
100
120
140
160
180
200



Source: GAO analysis of Centers for Medicare & Medicaid Services' data .

Note: Four states—Maine, Mississippi, Vermont, and Wyoming—reported $0 in expenditures related to the managed care and Medicaid premium assistance category.

Adjustments were made by adding expenditures reported in CMS-64 to those reported in the Medicaid Statistical Information System (MSIS). Specifically, we added Disproportionate Share Hospital payments, national and state rebates for prescription drugs, Medicaid health insurance payments, and Medicare premiums to the expenditures reported in MSIS. No adjustments were made for acute and long-term support services (LTSS)-noninstitutional and LTSS-institutional.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Robert Copeland, Assistant Director; Muriel Brown; Shaunessye Curry; Greg Dybalski; Sandra George; Giselle Hicks; Drew Long; Jessica Morris; and Monica Perez Nelson made key contributions to this report.

Related GAO Products

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