NAMD
National Association of Medicaid Directors

Rethinking Medicaid Program Integrity:

Eliminating Duplication and Investing in Effective, High-value Tools

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A Message from the Director

Nationally, over $366 billion spent (federal and state) on 59.5 million Medicaid recipients. The magnitude of such program that serves many of the most vulnerable individuals demands an equivalent and appropriate level of accountability – from federal and state governments, providers, enrollees and other stakeholders that touch the program.

Medicaid Directors are sensitive to their role as stewards of the public's trust. States are strongly committed to ensuring accurate payments and prevention of fraud, waste and abuse. They are working to ensure all dedicated resources produce a positive return on investment. To do so they increasingly are using more sophisticated tools for data mining and deployment of technology.

However, in recent years, Medicaid Directors have become concerned by the disjointed and ineffective approach to Medicaid program integrity. States are struggling to balance the maintenance of existing efforts and meeting new requirements, including coordination with a multitude of federal efforts. The challenges and concerns for every state are magnified during this period of historic change for the Medicaid program – and for the health care system broadly – as well as the ongoing budget constraints experienced by the vast majority of Medicaid agencies.

The confluence of these factors is precisely why Medicaid Directors believe now is the time to reexamine the current approach to Medicaid program integrity. States want to ensure that program integrity is about creating a health care culture where there are the incentives to provide better health outcomes and common sense ways to avoid over- or underutilization of services.

The following position paper describes the landscape of federal Medicaid program integrity activities. However it is more than a description of programs. NAMD offers a window into the duplication and inefficiencies that currently exist. We present Directors' perspectives on what is truly needed and recommendations for rethinking the approach to achieve these. Through their Association, Medicaid Directors are committed to working to achieve this vision.

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Introduction

Medicaid program integrity is among the highest priorities of the nation's Medicaid Directors and is a key component of every initiative and program states conduct. Throughout the nation's Medicaid agencies, Directors seek to promote economy, efficiency, accountability, and integrity in the management and delivery of services in order to ensure that they are effective stewards of the Medicaid program's limited resources.

States use multi-pronged strategies aimed first at prevention—the most critical ingredient to successful program integrity (PI). Auditors, analysts, and a host of other employees and consultants work to prevent the loss of public dollars to fraud and abuse. Recovery efforts supplement prevention, and include prosecuting fraud cases in court, and pursuing overpayments to providers when they cannot be prevented.

Program Integrity Defined

Program integrity is about creating a culture where there are consistent incentives to provide better health outcomes within a context that avoids over- or underutilization of services. It also requires effective program management and ongoing program monitoring at the federal and state levels. These efforts affect the ability of states and the federal government to ensure taxpayer dollars are spent appropriately. Effective program integrity will ensure:

- Accurate eligibility determination;
- Prospective and current providers meet state and federal participation requirements;
- Services provided to beneficiaries are medically necessary and appropriate;
- Medicaid remains the payer of last resort when other insurers or programs are responsible for an enrollee's care; and
- Provider payments are made in the correct amount and only for covered services.

Despite federal and state investments and a strong commitment to this vision of program integrity, these are the overarching challenges impeding effective implementation:

- Federal programs are typically not tailored to meet unique, state-identified fraud, waste, and abuse priorities and related program integrity activities, nor are they responsive to other inherent state variations such as state policies, program characteristics, and organizational structures.
- Federal requirements – those long-standing as well as recently added mandates – often force states to divert resources from highly effective activities.
- State and federal roles in the operation and oversight of program integrity efforts have blurred over time, creating overlap, inefficiencies, and confusion.
- Access to and utilization of federal data sources is challenging. Existing federal and state databases and data warehouses are not coordinated, difficult to navigate, and present limitations to the accessing of valuable investigative information.

NAMD proposes to work across states and with our federal partners to remedy these barriers to effective PI.

The program integrity landscape

Medicaid fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person and includes any act that constitutes fraud under applicable federal or state law. Waste is not currently defined in federal Medicaid regulations, however it is generally understood to encompass the over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act. Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care and health care coding. It also includes non-fraudulent recipient practices that result in unnecessary cost to the Medicaid program.

While all Medicaid programs have ultimate responsibility for combating fraud, waste and abuse, the scope and execution of program integrity activities varies by state. The authorities and delegation of these responsibilities can also differ based on the organizational structure and departmental roles. For example, in one state the Medicaid agency may carry out most if not all program integrity-related activities, while in other states these roles are spread across agencies. Finally, the scope of states' portfolio or definitions of program integrity can vary. For example, some but not all Medicaid agencies define coordination of benefits and third party liability activities as a core component of their program integrity efforts.

Despite the high priority Medicaid leaders at all level of government give to program integrity, truly effective programs are not possible in the current environment. Challenges to optimal program integrity include a lack of coordination across federal agencies, insufficient collaboration and ineffective communication with states by the various federal entities executing program integrity activities, and a *solution du jour* approach which simply layers untested approaches – each with their own bureaucracy and program requirements– on top of one another without ever pausing to look at what has worked and what has not. Resources dedicated to complying with unproven programs are simply a distraction for states and divert attention and resources from high-value program integrity activities.

While fighting fraud and abuse is important, there is no doubt the proliferation of agencies tasked with some role in Medicaid program integrity is responsible for considerable duplication. Medicaid program integrity involves various agencies at the federal level, including the following:

- Centers for Medicare and Medicaid Services' (CMS) Center for Program Integrity including its Medicaid Integrity Group (MIG),
- CMS' Office of Financial Management, and
- CMS' Center for Medicaid and CHIP Operations;
- HHS Office of the Inspector General (OIG);
- U.S. Department of Justice, including the Drug Enforcement Administration (DEA); and
- Federal Bureau of Investigations (FBI).

At the state level program integrity efforts are undertaken taken by the following:

- State Medicaid agencies;
- Medicaid Fraud Control Units (MFCUs);
- Separately elect State Auditors (where applicable);
- State Medicaid Inspector Generals (where applicable);
- State Attorneys General; and
- Others depending on the specific state.

A lack of information or faulty communication between these different levels of government and across all agencies, such as information sharing between the Medicare program and state Medicaid agencies, can dramatically reduce the effectiveness of both prevention and recovery efforts by both programs.

The following is a brief description of some of the primary federal programs.

Medicaid Eligibility Quality Control (MEQC). Federal regulations require states to conduct annual Medicaid eligibility quality control projects. States can choose whether to sample from the entire Medicaid population, or conduct special studies that focus on a specific group of recipients. Some states have received waivers to meet the MEQC requirements.

Medicaid Fraud Control Units (MFCUs). A Medicaid Fraud Control Unit is a single entity of state government, generally housed in the Attorney General's office, that conducts a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. In addition, a MFCU reviews complaints of abuse or neglect of nursing home residents. The Unit is also charged with investigating fraud in the administration of the program and for providing for the collection or referral for collection to the single state agency and overpayments it identifies in carrying out its activities. With the approval of the Inspector General of the relevant federal agency, MFCUs may investigate fraud in any federally funded health care program, such as Medicare, primarily related to Medicaid. MFCUs receive an annual federal grant from HHS, and the federal grant must be matched with 25 percent state funds.

Medicaid Integrity Contractors (MIC). The Deficit Reduction Act (DRA) of 2005 established the CMS Medicaid Integrity Program at CMS as part of a five-year program to combat fraud, waste and abuse. The MIC was one of the initiatives spawned by the additional funding provided to CMS. The MIC is a CMS selected and funded contractor that operate in three distinct components (data, audit, and education) in each of the CMS regions. The data contractor searches state MSIS data housed in the CMS data center for aberrant providers, which are then audited by the audit contractor. The state must recover the CMS identified overpayment and return the federal share of the overpayment.

Medicaid Integrity Group (MIG) reviews. The Medicaid Integrity Group is an outgrowth of the additional funding CMS received in the Deficit Reduction Act (DRA). The intent of the MIG review is to determine that the states are complying with the program integrity requirements in Title 42 CFR, including that the Medicaid agency has a plan for the identification, full investigation, reporting, and referral of suspected fraud and abuse cases to appropriate agencies.

Medicare-Medicaid Data Match Program (Medi-Medi). The Medicare-Medicaid Data Match Program, or "Medi-Medi," initially began in California to detect and prevent Medicaid fraud and abuse. The program expanded to other states, and with the passage of the Deficient Reduction Act of 2005, funding increased to roll out the program nationwide. Medi-Medi is accomplished by using computer algorithms to combine Medicaid and Medicare data to identify improper billing and utilization patterns. Medi-Medi includes state, regional, and national efforts and requires collaboration among state Medicaid agencies, CMS, and state and federal law enforcement officials. CMS selects Zone Program Integrity Contractors (ZPICs) that consolidate Medicare Parts A, B, C, D, and Medi-Medi Benefit Integrity Activities.

Payment Error Rate Measurement (PERM). The PERM process was developed by CMS as a response to the Improper Payments Information Act of 2002 (IPIA). Under PERM, reviews are conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid and CHIP programs. The results of these reviews are used to produce national program error rates, as required under the IPIA, as well as state-specific program error rates. CMS has developed a national contracting strategy for measuring the first two areas, FFS and managed care. States are responsible for measuring the third area, program eligibility, for both programs. Because states administer Medicaid and CHIP according to each state's unique program, the states necessarily need to be participants in the measurement process.

Recovery Audit Contractors (RAC). The RAC is a contingency fee based contractor program mandated by the Affordable Care Act. While CMS has provided states flexibility in the contracting and operation of their individual RAC programs, the RAC program audits the same state claims from state data for overpayments and for mandated identification of underpayments as MICs. Further, the RAC is reimbursed at a contracted percentage of the identified improper payments identified, which cannot exceed the highest rate for a Medicare RAC, currently 12.5 percent. Complicating the contracting with RACs is the fact that the contracted percentage can change every year based on how the CMS contracts for Medicare and that the percentage can be higher for DME.

Recommendations for strengthening the approach to Medicaid program integrity

States are fully committed to working with federal policymakers and agencies to improve the integrity of the Medicaid program. However, the nation's Medicaid directors seek to ensure that resources go only to effective, high-value initiatives. Realizing this goal will require more deliberate communication between federal and state leaders. Specifically, federal and state policymakers should meet face-to-face to coordinate and clarify our respective roles, to define our visions and expectations for a high-performing Medicaid program, and to create pathways for collaboration and sharing tools across all levels of government. Meaningful dialogue between states and federal leaders could lay the foundation for ongoing, two-way learning on these critical aspects of program integrity.

Below are specific recommendations to federal and state leaders for strengthening the integrity of the Medicaid program.

Clarify the roles of the state and federal governments

One of the first steps for federal and state leaders is to define their respective roles. Prior to enactment of the Deficit Reduction Act of 2005 (DRA), states and the federal government had more distinct roles in fraud, waste, and abuse efforts, with states operating the programs and CMS serving as the overseer of state activities. The DRA's relatively significant investment in federal Medicaid PI corresponds with the increase in layering of federal programs and requirements as well as an imbalance in the resources available to addresses federal requirements.

Medicaid PI efforts are undermined where federal and state roles have blurred. The ambiguity has led to significant duplication and inefficiency as well as confusion about information sharing and which entity is carrying out any particular activity. Overlapping and duplicative activities also can make it difficult to meet intended deadlines.

One example where this occurs is with the Medicaid Integrity Contractors (MICs). States are supportive of the work underway by the MIC education contractors to create educational material intended for providers and also believe the MICs could do more to look at multi-state eligibility issues and multi-state provider activities. However, other components of the MIC initiative present significant problems. Specifically, duplication and confusion occurs with the activities of the MIC audit contractors and the additional work they create for Medicaid PI units. Most recently, implantation of the RAC requirements appears to be exacerbating this phenomenon through apparent duplication of responsibilities and efforts of the MIC's and the RAC's. Other problems plaguing the Audit MIC program include insufficient coordination with states when MICs contact providers and mine state data and the use of the Medicaid Statistical Information System (MSIS) data for the audits. As described in the HHS OIG's February 2012 report, "Early Assessment of Review Medicaid Integrity Contractors," the MSIS data used by the Review MICS lacks information important for conducting program integrity activities.

Without a doubt, states are the front line for preventing, identifying, and remediating fraud, waste, and abuse in their respective Medicaid programs. However, Medicaid program integrity

requires a collaborative model between and among all governmental entities. Further, the collaborative model is multi-pronged. That is, federal agencies, particularly within CMS, must improve their internal coordination and, in turn, federal agencies must collaborate with ongoing activities with the states. In addition, states and federal policymakers must focus on improving responsiveness to problems as identified and rapid course-correction to ineffective approaches and programs.

Improve collaboration and communication between Medicare and Medicaid

Medicaid Directors also call on federal policymakers to convene a task force dedicated to addressing the obfuscated relationship between Medicaid and Medicare program integrity activities. One logical convener for this effort is CMS' Medicare-Medicaid Coordination Office, which has demonstrated unprecedented ability to bridge challenging issues between the two programs.

Despite common interests in program integrity and overlap in enrolled beneficiaries and providers, the current fragmented relationship between the two programs creates overlap and undermines federal and state efforts. For example, site verification for nursing homes and other facility-based providers and provider screening are required for both Medicare and Medicaid. However, there is no pathway for the two programs to build on or leverage their respective efforts.

This task force, with participation by all relevant agencies at HHS as well as the states, should be charged with defining the respective roles and developing policy recommendations aimed at the following:

- Breaking down the long-standing barriers to communication and improving collaboration between the two programs;
- Eliminating duplication of effort on activities that touch the same providers, beneficiaries or other stakeholders;
- Transitioning federal resources to initiatives that address the needs of the states;
- Creating a vehicle for rapid course-correction to ineffective initiatives; and
- Creating a pathway for states to leverage Medicare's powerful data analytics, predictive modeling and other information and resources.

While working to harmonize efforts, Medicaid Directors also ask federal policymakers to carefully consider any future federal legislation that seeks to apply Medicare-specific requirements and programs to Medicaid. These programs serve populations with different needs and work with a wider range of providers. These fundamental differences combined with variations in state Medicaid programs, policies, and organizational structures create conflict when a program originally designed for Medicare is simply mandated to apply to the Medicaid program.

Instead, when legislating or implementing new programs, these differences must be recognized and incorporated and proposed with feasible implementation timelines. Further, the federal government should define its success measures up front as new initiatives start in order to make more informed decisions about the appropriateness of applying Medicare initiatives to Medicaid.

Invest in resources tailored to unique state Medicaid programs

States are the front line for protecting the integrity of the Medicaid program, including identifying and preventing fraud, waste and abuse and remediating those situations where it does occur. They are best situated to identify and target resources to program vulnerabilities. Medicaid Directors also believe program integrity must include a focus on reorienting the Medicaid payment and delivery structures to pay for high-value services. However, increasingly the federally-driven approach to fighting fraud, waste and abuse require Medicaid programs to redeploy staff from state-level programs that may be yielding good results.

The federal government should support states in sustaining successful programs or further refining their efforts to meet unique state needs and conditions. The following overarching principles are aimed at reprioritizing and guiding the federal and state focus on prudent investments that support implementation of only the most effective PI practices.

Collaborate with states to develop targeted efforts to support high-performing Medicaid programs. Policymakers must rethink the current approach to fighting fraud, waste, and abuse in the Medicaid program. Through our Association, Medicaid Directors propose to work with federal policymakers to develop a broader, shared understanding of high-performing Medicaid programs. Based on fact-based research a checklist defining a high-performing Medicaid system could inform a common understanding of the effectiveness and efficiency of each state's Medicaid program.

Benchmarks, vehicles for sharing best practices, and processes for directing resources to high-value activities should flow from this vision. Specifically, Medicaid Directors ask that CMS redirect the focus and resources of the Medicaid Integrity Group (MIG) away from conducting reviews of Medicaid integrity programs. States are the front line for identifying and prioritizing the threats to program integrity in each of their programs. Therefore, the MIG should increasingly dedicate its resources to the formation and deployment of consulting teams to work with individual states to identify their challenges and to assist them in implementing efficiencies in their PI programs, which may include a single source contract to perform pre- and post-payment results.

For example, federal assistance could support various activities, including the following:

- Support state initiatives to increase training, education, and implementation of tools to improve the sophistication of their program integrity activities;
- Focus resources where states believe there are vulnerabilities, including in the areas of newly evolving integrated care models, for various aspects of PI for managed care programs, and home and community based services;
- Assist states with inter-state or inter-county initiatives; and
- Assist states with drug rebate recoveries.

Ultimately these and other state-focused and state-driven initiatives should lead to a more rational approach to promote the proper expenditure of Medicaid program funds, improve program integrity performance nationally, and ensure the operational and administrative excellence of the Medicaid integrity program.

Medicaid Directors also support the inclusion of an evaluation component for all existing and any federal fraud, waste, and abuse program going forward. A comprehensive assessment of program performance and outcomes will put fraud, waste and abuse programs on par with other efforts to measure the effectiveness and efficiency of other aspects of the Medicaid program.

Leverage federal investments in technology and data analytics tools. Medicaid Directors call on federal policymakers to make more strategic investments to expand the use of technology and data analytics tools for the Medicaid program. While some states have recently invested in more advanced data analytics tools that have helped them move further from "pay-and-chase" models of detecting fraud, additional federal support could speed implementation and maximize the use of these critical tools. In particular, CMS is able to negotiate the purchase of analytical tools at a price far lower than what any one state could negotiate on its own. States would like the ability to license federal technology or collaborate on other technical assistance resources, such as access to the expertise and tools for predictive analytics and data mining techniques that Medicare has developed in recent years.

Prioritize support for the Medicaid Integrity Institute. States strongly support ongoing and augmented investment in the Medicaid Integrity Institute (MII). The MII is the first national Medicaid program integrity training center for states. Since 2007, the MII has focused on developing a comprehensive program of study addressing aspects of Medicaid program integrity including fraud investigation, data mining and analysis, and case development.

MII helps ensure that program integrity staff stay informed of current trends and receive formal training. By doing so, it enables staff to more successfully identify fraud, waste and abuse, which in turn makes more efficient use of federal and state Medicaid funds. The training needs of the employees from state Medicaid program integrity units are the primary focus; however, employees from other Medicaid divisions also participate depending on the course objectives. Medicaid Directors support the MII's effort to grow the impact of this program through increased support, and the development of certifications and accreditation for MII program participants. Additional participation by CMS and other federal agency staff could help improve understanding and collaboration with states.

Include state Medicaid perspectives in federal audits on Medicaid fraud, waste, and abuse programs. In addition to evaluations, Medicaid Directors request that federal audits and reports about Medicaid program integrity include a state review requirement and an opportunity for formal state response to the report, similar to the process used by the Government Accountability Office when it evaluates federal agency activities and programs. Through our Association, Medicaid Directors are committed to working with federal partners to ensure a comprehensive, balanced analysis is provided to Congress and other stakeholders so that policymakers may act on the feedback as to how improve federal initiatives.

Evaluate the return on investment and utility of existing program integrity initiatives

Currently the federal oversight culture is focused on bureaucratic, and, at times, counterproductive processes to the detriment of better care for enrollees and value for the program. Within this context, states must dedicate limited staff resources to programs with negative, minimal, or no proven value to either states or the federal government. For example,

day-to-day functions are where many of the erroneous payments occur. However, states increasingly must divert limited IT resources to CMS-mandated projects rather than investing them in necessary, day-to-day operations of effective PI efforts.

At a minimum revamping federal fraud, waste and abuse requires the following:

- Forthright evaluation and corrective action that will eliminate existing programs that are misguided, duplicative, or ineffective.
- Accurate assessment of the financial support necessary for either CMS or states or both to develop and implement new activities and programs.
- A commitment and administrative actions to align incentives, particularly with regard to requirements for states to recoup funds.

As a first step, federal and state policymakers should collaborate in evaluation and streamlining of the following programs.

MICs and RACs. Medicaid Directors request federal policymakers eliminate the glaring overlap between the Medicaid Integrity Contractor (MIC) and the Recovery Audit Contractor (RAC) programs. Both federal initiatives will be auditing providers in addition to the state program integrity efforts in fee-for-service states. For states that rely heavily on managed care organizations the issue becomes even more complicated as the managed care contractors have internal program integrity efforts and many have their own contracted RACs. The duplicative efforts are forcing states to maintain complex databases simply to track various audit trails. That is, depending on which particular auditing entity identifies a problem (i.e. the state agency, MICs, RACs, etc), recovery must follow that audit, and when multiple audits identify the same problem, it becomes incredibly complex to determine the payment trails.

To the extent Congress continues to require and CMS operates these two programs, a rational, immediate, and relatively easy way to reduce the resource consumption by duplicative and lowest return on investment (ROI) audit functions would be to exempt states from certain audits, specifically MICS and/or RACS, for one or more audit cycles based on previous findings of a low rate of error.

Audit MICs. As previously noted, Medicaid Directors have concerns with state resources invested in and the utility of Audit MICs. States note that the Audit MICs have used outdated MSIS data – including one state that reported the auditors used six-year old MSIS data as a starting point for claims. Additionally, Audit MICs may be duplicating some of the algorithms used by states and not follow all state-level criteria, such as record retention requirements.

Medicaid Directors request that Congress and CMS undertake a thorough evaluation of the ROI of the Audit MIC program, including the protocols for conducting the audits and coordination with the Review MICs, the validity of the data reviewed, and the process for consultation with states. Given the differential impact depending on the size of state Medicaid programs, this review must look at the return for states on an individual basis, and not simply a national ROI. Directors recommend eliminating the Audit MIC program – and other programs -- that do not demonstrate a reasonable ROI for federal and state partners.

MIG reviews. Federal policymakers should undertake a cost effectiveness evaluation of the Medicaid Integrity Group (MIG) review, including an assessment of MIG review overlap with the

State Program Integrity Assessment (SPIA). The purpose of the MIG review is to determine that the states are complying with the program integrity requirements in Title 42 CFR, as well as, to identify best practices that can be shared with other states. States report that initial reviews were a fairly productive venture that provided an independent review of operations and some helpful recommendations.

However, in subsequent MIG cycles, the reviews have lost focus and become unwieldy. The time and effort states expend to complete the extensive review guides and the production lost from a week-long review produce, at best, a questionable return on investment for states. The review guides themselves have expanded exponentially. The onsite review with CMS staff occupy key state program integrity staff for several days and require extensive time and staff contributions from senior managers for various divisions, such as provider services, the General Counsel, fiscal services, and network operations. Additionally these reviews may require a significant level of participation from all managed care plans, the pharmacy benefit manager, and the dental benefit manager.

In addition, MIG efforts to share best practices have generally been limited in nature. At a minimum, MIG staff should be directed to disseminate findings among state Medicaid officials. In addition, the MIG should intensify its focus on efforts to develop a standard cost avoidance methodology that could be used by states to demonstrate greater savings beyond what is actually recouped. Such a tool would provide an opportunity to more accurately assess the value of federal and state activities.

Medi-Medi. Medi-Medi continues to fall short of full, effective implementation despite significant investments of federal funding to build a data repository and expand the program. As mentioned early, states seek the opportunity to have a thorough dialogue on this issue through a task force. In the meantime, states have identified the following concerns with this program:

1) States review inappropriate payments to identify if there are opportunities to implement edits in their payment systems. However, the broader state approach to program integrity does not fit well with the federal Medi-Medi Project and its contractors, which are solely focused on generating law enforcement referrals.

2) Database development and data access continue to experience operational hurdles. Some participating states report that assumptions about the relationship of Medicaid data fields/definitions to Medicare data fields/definitions were frequently incorrect, requiring revisions. Thus, some participating states have found that the resulting database is neither intuitive nor simple to access and use for data mining. Further, as states implement new MMIS, this will likely require re-mapping and extracting of data.

3) States believe the CMS contractor concentrates on Medicare payments with a secondary focus on Medicaid payments. Further, Medicare and Medicaid billing and payment policies differ greatly. In some states, significant state resources have been utilized to explain why Medicaid data, wrongly analyzed using Medicare policy by CMS contractors, did not present any evidence of violation of Medicaid rules/procedures.

PERM and MEQC. There are also multiple federal programs that audit Medicaid eligibility processes, specifically the Medicaid Eligibility Quality Control (MEQC) program and the Payment Error Rate Measurement (PERM) program. While states have ongoing concerns with certain

aspects of the PERM program, generally they believe it appears to be complete review for both eligibility and claims. Despite efforts to integrate the MEQC process with PERM, Medicaid Directors believe MEQC has long outlived its useful life.

PERM. There are three fundamental problems with PERM– as well as other audit programs – that impede its well-intentioned goals:

1) The required PERM audits duplicate other federal and state audit activities and create confusion and additional burden for the providers involved.

2) PERM is frequently mischaracterized or misunderstood as a measure of fraud in Medicaid programs. There is a clear need for federal agencies to reinforce that PERM is a snapshot in time of the percentage of claims that are identified as *potential* errors. PERM errors do *not* equate to a percentage of dollars in error or potential savings to a Medicaid program.

3) There is a lack of common understanding of what qualifies as an error in PERM. In other words there are too many instances where federal regulations, as well as the federal contractors carrying out the audits, fail to accurately interpret and apply state policies for the PERM project or where federal timelines conflict with state timelines for processing claims. In turn, the PERM rates are not an accurate reflection of program integrity in most states.

Focus on streamlining and improving access to data

Better data systems and expanded access to existing systems are essential for improving efforts to prevent, identify, and where appropriate, take action in response to Medicaid fraud, waste, and abuse. While states are making progress, many still have inadequate technological infrastructures and a basic inability to interrogate databases efficiently to ferret out improper claims. A number of states indicate that they need better, more targeted data, to pinpoint areas most likely to foster problems, as well as guidance and technical assistance on acquiring new data systems and other fraud and abuse detection tools.

Leverage Medicare data. Working through our Association, Medicaid Directors are committed to partnering with federal policymakers to develop reasonable policies and functional data exchange systems between Medicare and Medicaid. Despite investments in projects like the Medicare-Medicaid Data Match Program, commonly referred to as “Medi-Medi”, coordination between Medicare and Medicaid remains insufficient and ineffective in many states.

Reconciling differences in data formats between Medicare and Medicaid requires tremendous time and state resources, and can sometimes impede state efforts to use this information in a timely, effective manner, even when it is made available to them. Medicare and Medicaid billing and payment policies differ greatly. In order to be successful in efforts to protect the integrity of Medicare and Medicaid, state and federal governments must work together on the appropriate scope and format of data that is shared as well as the relationship with CMS contractors. In addition, sharing Medicare Part D data (including price information) and data matches with the Drug Enforcement Agency (DEA) would significantly enhance state program integrity efforts by helping to reduce fraud, waste and abuse.

Coordinate the "build" of any Medicaid data warehouses. There are significant federal efforts under way to build data sources that house Medicaid data. While such data warehouses have the stated purpose of strengthening federal and state program integrity initiatives, the current approach is lacking in at least two major ways.

First, the federal efforts currently underway appear fragmented, with multiple overlapping "pilots" led by multiple CMS contractors. These contractors are typically unable to articulate to states how the efforts relate to the overall vision and goals for Medicaid program integrity initiatives. Further, states report that few of these contractors bring any knowledge or understanding of Medicaid data. Medicaid Directors urge CMS to ensure that when states invest valuable state resources in the development of an analytic database, the utility to states is clearly documented, particularly when assessing this investment against competing state priorities.

Improve collaboration between Medicaid and the HHS OIG. Medicaid Directors most frequently interact with the HHS OIG as part of federal audits. However, states believe increased communication and collaboration and review of OIG methodologies could prove more effective for all levels of government.

Medicaid Directors particularly seek to work more closely with the OIG to identify priority targets for investigations on an individual and/or state specific basis. Medicaid Directors wish to collaborate with the OIG to review current investigative methodologies, specifically the sampling methodology. We believe this review is necessary in order to address current concerns with methodologies that lead to overstated overpayments.

States also wish to work with the OIG to address inefficiencies with various databases. For example, CMS requires monthly searches of overlapping federal databases to identify any excluded providers and contractors. These monthly data matches must identify excluded individuals who have been convicted of health care fraud. The (OIG) maintains the List of Excluded Individual/Entities (LEIE) database, but the LEIE is not user friendly and only allows a small number of names and social security numbers (SSN) to be searched at any time. This places a significant burden on states, managed care organizations, providers, etc. In addition, the LEIE does not a maintain history of exclusions and does not include dates when exclusions started. In an attempt to improve inefficiency, CMS created a MED database that is downloadable with names and SSNs, but will only allow *states* to download the database. It cannot be shared with managed care entities or providers. Federal agencies should streamline and improve access to key information to minimize these burdensome processes.

CMS also requires states, managed care plans, providers, etc. to search the Excluded Parties List System (EPLS) maintained by the General Services Administration (GSA) for parties excluded from contracting with the Federal government. This is onerous for states because it only allows a limited number of parties to be searched at one time and has no capability for any of the previously mentioned groups to download the database to match against current providers, employees, etc. Medicaid Directors urge federal policymakers to consider creating a single database that would combine the LEIE, EPLS, data on terminated providers, HHS' Healthcare Integrity & Protection Database, which collects data on healthcare-related civil judgments and criminal convictions, injunctions, federal and state licensing actions, exclusions, and any other adjudicated actions defined in HIPDB regulations, as well as other databases states are supposed to be checking, such as the Social Security Administration's Death Master File. This approach has

the potential to allow states to fully automate the match while not generating lists of "suspect matches" for manual follow up.

Conclusion

State Medicaid Directors face more than programmatic hurdles in their race to bend, shape and re-tool their programs. We look forward to working with Congress, the Administration, and other stakeholders to address not only the potential barriers to improved program integrity in Medicaid, but the need to encourage, support and inform innovation on a scale equal to Medicaid's critical role as the nation's health care safety net.

The National Association for Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD provides a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of its member states now and in the future.