

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PUBLIC ASSISTANCE
REPORTING INFORMATION
SYSTEM: STATE
PARTICIPATION IN THE
MEDICAID INTERSTATE
MATCH IS LIMITED**



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EXECUTIVE SUMMARY – PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM: STATE PARTICIPATION IN THE MEDICAID INTERSTATE MATCH IS LIMITED, OEI-09-11-00780

WHY WE DID THIS STUDY

In 2013, eligibility errors caused an estimated 57 percent of improper Medicaid payments, representing approximately \$8.2 billion in Federal expenditures. One type of eligibility error occurs when beneficiaries remain enrolled in a State’s Medicaid program for which they are ineligible because they are no longer residents of the State and/or have failed to timely report a change in circumstances (i.e., address and residency) to the State. The Public Assistance Information Reporting System (PARIS) Medicaid Interstate Match is an important tool that has the potential to reduce improper Medicaid payments by identifying beneficiaries who are enrolled in multiple State Medicaid programs. Although the Social Security Act (SSA) mandates that States participate in the match, neither the SSA nor guidance from the Centers for Medicare & Medicaid Services (CMS) defines the meaning of such participation.

HOW WE DID THIS STUDY

We discuss “participation” in the Medicaid Interstate Match as four steps that States perform to reduce improper payments: (1) submitting Medicaid enrollment data, (2) verifying matches, (3) discontinuing Medicaid benefits for ineligible beneficiaries, and (4) recovering any improper Medicaid payments. To determine the extent to which States participate in the match, we gathered information from States for a random sample of 300 matches from the August 2011 match. We conducted structured interviews with officials from CMS to determine the extent to which they provided guidance to States on the four steps. Finally, we conducted a survey of State Medicaid agencies and collected their match policies to determine the extent to which States have policies on the four steps.

WHAT WE FOUND

States’ participation in the Medicaid Interstate Match is limited. CMS guidance to States for participating in the match is limited, and States reported that they needed more guidance. Most States had policies addressing at least one of the steps for participating in the match.

WHAT WE RECOMMEND

We recommend that CMS issue guidance to States on the requirement for participating in the Medicaid Interstate Match. CMS concurred with our recommendation.

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OBJECTIVES

To determine the extent to which:

1. States participate in the Public Assistance Reporting Information System (PARIS) Medicaid Interstate Match,
2. the Centers for Medicare & Medicaid Services (CMS) provides guidance to States for participating in the PARIS Medicaid Interstate Match, and
3. States have policies and procedures for participating in the PARIS Medicaid Interstate Match.

BACKGROUND

CMS estimates that nationally, 5.8 percent of Medicaid payments made in fiscal year 2013 were improper, representing \$14.4 billion in Federal expenditures.¹ Eligibility errors caused an estimated 57 percent of these improper payments,² representing approximately \$8.2 billion in Federal expenditures.³ One type of eligibility error occurs when beneficiaries remain enrolled in a State's Medicaid program for which they are ineligible because they are no longer residents of the State and/or have failed to timely report a change in circumstances (i.e., address and residency) to the State. Therefore, procedures to capture and share State residency changes are essential for reducing improper payments resulting from beneficiary enrollment in multiple State Medicaid programs.⁴ PARIS is an important tool that has the potential to reduce improper Medicaid payments by identifying beneficiaries who are enrolled in multiple State Medicaid programs.

PARIS

PARIS provides all 50 States, the District of Columbia, and Puerto Rico⁵ (States) with information to aid them in detecting and preventing improper payments in the administration of public assistance and medical assistance

¹ Department of Health and Human Services (HHS), *Fiscal Year 2013 Agency Financial Report*, December 16, 2013, p. 173.

² For the purpose of this report, we use the term "improper payments" to encompass both erroneous payments caused by eligibility errors and improper payments resulting from potential fraud.

³ Office of Inspector General (OIG) analysis based on CMS numbers, *Fiscal Year 2013 Agency Financial Report*, December 16, 2013, p. 173.

⁴ There are conditions under which States may pay for services received by a beneficiary in more than one State, which include, but are not limited to, medical emergencies. 42 CFR § 431.52.

⁵ Puerto Rico is the only United States territory participating in PARIS.

programs. PARIS consists of three types of matches—a Federal Match,⁶ a Veterans Affairs Match,⁷ and an Interstate Match. The Interstate Match provides States with information about individuals who are enrolled in various types of State health and public assistance programs in multiple States. One type of Interstate Match is the Medicaid Interstate Match, which takes Medicaid enrollment data from one State and matches it to Medicaid enrollment data from other States to identify beneficiaries who are enrolled in multiple State Medicaid programs.⁸

The Administration for Children and Families (ACF). ACF, an agency within HHS, facilitates the PARIS matches and provides information to States about PARIS. As part of its responsibilities for Federal programs that promote the economic and social well-being of children, families, and communities, ACF coordinates with States to ensure that they sign the required annual memorandums of understanding to participate in the PARIS matches.⁹ ACF also maintains a Web site and sponsors an annual conference to provide information to States regarding PARIS.

Federal Requirements for the Medicaid Interstate Match

State participation in the Medicaid Interstate Match is required by the Social Security Act (SSA) as a condition of receiving Medicaid funding for automated data systems.¹⁰ Effective October 1, 2009, the SSA required States to have a system for determining Medicaid eligibility that provides for data matching through PARIS or any successor system.^{11, 12}

⁶ The Federal match provides States with information by matching State data with information from the Department of Defense and the Office of Personnel Management. This match determines whether beneficiaries receive income from either of these sources or are eligible for Federal health care coverage. PARIS, *Federal Match Files: User Manual*, December 2008, p. 1.

⁷ The Veterans Affairs match provides States with information on the eligibility of their public and medical assistance beneficiaries for veterans' benefits and allows States to confirm whether their beneficiaries receive income and/or medical assistance payments from the Department of Veterans Affairs. Altarum Institute, *PARIS Cost-Benefit Analysis—Final Report*, December 2008, p. 3.

⁸ The Interstate Match also matches enrollment data from the following public assistance programs: Temporary Assistance for Needy Families, the Supplemental Nutritional Assistance Program, the Childcare program, and Worker's Compensation.

⁹ The annual memorandum of understanding certifies States' compliance with procedures for information technology security. ACF, *Memorandum of Understanding Interstate Data Matching by State Public Assistance Agencies*. Accessed at <http://www.acf.hhs.gov/programs/paris/appendix-3m> on November 5, 2013.

¹⁰ SSA § 1903(r)(3). States may receive payments for automated data systems authorized by SSA § 1903(a)(3) only if they meet the requirements of SSA § 1903(r)(3).

¹¹ As of the date of this report, a successor system does not exist for PARIS.

¹² SSA § 1903(r)(3).

CMS Guidance for the Medicaid Interstate Match. CMS administers the Medicaid program and has the responsibility to issue guidance regarding States' participation in the Medicaid Interstate Match. In June 2010, CMS issued a State Medicaid Director Letter (SMDL) to provide formal guidance to State Medicaid agencies on complying with the requirement at section 1903(r)(3) of the SSA that requires States to participate in PARIS. According to the guidance, each State must—to demonstrate compliance with the requirement—amend its Medicaid State plan to document its participation in PARIS.¹³ However, neither the SSA nor the SMDL defines the meaning of “participation” as it relates to the match.

Medicaid Interstate Match Process

States submit Medicaid enrollment data to the Defense Manpower Data Center (DMDC), which conducts the Medicaid Interstate Match.¹⁴ DMDC conducts quarterly matches in February, May, August, and November of each year. For each quarterly match, DMDC uses the enrollment data submitted by States and compares the Social Security Numbers (SSNs) of enrolled beneficiaries from one State to those of beneficiaries enrolled in other States, thereby identifying beneficiaries who are enrolled in multiple State Medicaid programs. For these beneficiaries, DMDC then generates matches that contain enrollment data from the States with Medicaid programs in which the beneficiary is enrolled. DMDC compiles the matches into a “match file” and sends it to the appropriate States.

Reducing Improper Payments Through Participation in the Medicaid Interstate Match

Although neither the SSA nor the June 2010 SMDL defines what constitutes State participation in the Medicaid Interstate Match, we identified four steps that States perform to reduce improper payments through their participation in the match. The four steps include (1) submitting Medicaid enrollment data to DMDC, (2) verifying matches (i.e., determining the Medicaid eligibility of the beneficiaries listed in the match file), (3) discontinuing Medicaid benefits for ineligible beneficiaries, and (4) recovering any improper Medicaid payments.

Submitting Medicaid Enrollment Data. States receive an email from ACF that provides the deadline for submitting Medicaid beneficiaries' enrollment data for each quarterly Medicaid Interstate Match. States participating in that quarterly match must electronically submit their

¹³ CMS, *SMDL: Public Assistance Reporting Information System (PARIS)*, SMDL#10-009, June 21, 2010.

¹⁴ DMDC is a Department of Defense contractor that conducts all the PARIS matches.

enrollment data to DMDC by the deadline.¹⁵ At a minimum, States are expected to submit enrollment data for the quarterly match conducted in August of each year.¹⁶ Neither the SSA nor the SMDL indicates whether States are required to submit enrollment data for all of their Medicaid beneficiaries.

The Medicaid enrollment data that States submit to DMDC for the Medicaid Interstate Match include a variety of information. Examples of the information include the beneficiary's name, SSN, date of birth, address, sex, marital status, and Medicaid eligibility dates (i.e., the start and end dates of Medicaid coverage).¹⁷

Verifying Matches. After State Medicaid agencies receive their match information from DMDC, agency staff may verify the matches (i.e., determine whether the beneficiary is eligible to receive benefits in their State). Because DMDC uses only the SSNs to identify beneficiaries who are enrolled in multiple State Medicaid programs, State Medicaid agency staff use the Medicaid eligibility dates in the match file to determine whether the beneficiaries' coverage periods for their State overlap with those for other States.¹⁸ Overlapping coverage periods indicate that the beneficiary is simultaneously enrolled in multiple State Medicaid programs. Other verification activities can include requiring a beneficiary to come into the State Medicaid agency's office to show proof of residency, mailing a residency verification letter to the beneficiary, and/or contacting another State to determine whether the beneficiary is still enrolled in that State's Medicaid program.

Discontinuing Medicaid Benefits. If State Medicaid agency staff verify a match and determine that a beneficiary is ineligible to receive Medicaid benefits in that State, they may initiate action to discontinue the beneficiary's benefits.¹⁹ By discontinuing such benefits, States can reduce improper payments to the managed care organizations and fee-for-service providers that participate in their Medicaid programs.

Recovering Improper Medicaid Payments. If State Medicaid agency staff determine that their program made improper payments for a beneficiary whose Medicaid benefits were discontinued, the State may attempt to recover these improper payments. States may treat these improper

¹⁵ ACF, *Instructions for DMDC electronic file transmission on the PARIS project*. Accessed at <http://www.acf.hhs.gov/programs/paris/instructions-for-dmdc-electronic-file-transmission> on September 16, 2013.

¹⁶ Ibid.

¹⁷ 70 Fed. Reg. 40690 (July 14, 2005).

¹⁸ A coverage period is the period during which an individual is entitled to benefits.

¹⁹ Government Accountability Office (GAO), *PARIS Project Can Help States Reduce Improper Benefit Payments*, GAO-01-935, September 2001, p. 5.

payments to managed care organizations and fee-for-service providers as overpayments, and recover them accordingly.²⁰ Once an improper payment is identified, State Medicaid agency staff refer the matter to the appropriate State component to recover these Medicaid payments. The criteria for recovering improper Medicaid payments vary by State; therefore, not all improper payments may result in recoveries.

Related Work

In 2008, a series of OIG audits found that millions of dollars were paid for Medicaid services on behalf of beneficiaries who should not have been eligible because of their residency. One of these audits found that the District of Columbia paid \$1.9 million from July 2005 to June 2006 for Medicaid services provided to beneficiaries who should not have been eligible because of their residency in Maryland.²¹

Other reports have been issued saying that there are issues with how States verify matches from the PARIS Interstate Match. For example, in 2001, a GAO report found that States participating in PARIS gave little or no attention to interstate matches, allowing matches to go unresolved.²² Also, an ACF-commissioned report that looked at a sample of 14 States found that not all 14 were verifying the majority of the matches from the PARIS Interstate Match.²³

METHODOLOGY

Scope

Our evaluation is national in scope and focuses on States' participation in the Medicaid Interstate Match. We used DMDC's match files from the August 2011 match because States are expected to, at a minimum,

²⁰ SSA § 1128J, added by the Patient Protection and Affordable Care Act, P.L. No. 111-148 § 6402 (March 23, 2010), as amended by the Health Care Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), collectively known as the ACA. Overpayments are funds that a person receives or retains under the Medicaid program, to which the person, after applicable reconciliation, is not entitled. Once an overpayment is identified and not returned within the deadlines in SSA § 1128J(d)(2), the overpayment becomes a debt owed to the Federal Government. Under SSA § 1128J, beneficiaries are not liable for overpayments.

²¹ OIG, *Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in the District of Columbia and Maryland for July 1, 2005, Through June 30, 2006: The District of Columbia Department of Health*, A-03-07-00214, April 2008, p. 3.

²² GAO, *PARIS Project Can Help States Reduce Improper Benefit Payments*, GAO-01-935, September 2001, p. 15.

²³ Health Systems Research, Inc., an Altarum Company, *Evaluation to Determine the Effectiveness of the Public Assistance Reporting and Information System—Final Report*, June 2007, p. 34. Accessed at <http://www.acf.hhs.gov/sites/default/files/files/PARISFinal082007.pdf> on September 18, 2013.

participate in this quarterly match.^{24, 25} To allow States adequate time to verify matches from the August 2011 match, we continued to collect data through November 2012. The findings in this report are projected to all the matches in the August 2011 match.

Data Collection and Analysis

We used three data sources for our analysis: (1) DMDC match files from the August 2011 match, (2) structured interviews with CMS officials, and (3) a survey of the 52 State Medicaid agencies.

DMDC Match Files From the August 2011 Medicaid Interstate Match. To determine the extent to which States participate in the Medicaid Interstate Match, we obtained from DMDC all match files from the August 2011 match and selected a simple random sample of 300 matches. Overall, the August 2011 match files identified 159,964 matches from all States. The sample of 300 matches allows us to project the results of our analysis nationally to all the matches in the Medicaid Interstate Match for that quarter. We are projecting only to those Medicaid beneficiaries whose enrollment data was submitted for the quarterly Medicaid Interstate Match conducted in August 2011. For the statistics we project in this report, the estimates and 95-percent confidence intervals are listed in Appendix A.

For each match in the sample, we gathered information from all States that submitted Medicaid enrollment data for the beneficiary. For the beneficiaries in our sample of matches, we asked States whether they had verified the match(es) to determine the beneficiaries' eligibility. If a State had done so and determined that a beneficiary was no longer eligible for benefits in its State, we asked whether the State discontinued the beneficiary's benefits. If the State had discontinued the benefits, we asked it to provide the amount of improper Medicaid payments it made on behalf of the beneficiary and whether it recovered any of this amount.

From the sample of matches and States' responses, we projected the following information:

- the percentage of matches from the August 2011 match that States verified; and

²⁴ ACF, *Instructions for DMDC electronic file transmission on the PARIS project*. Accessed at <http://www.acf.hhs.gov/programs/paris/instructions-for-dmdc-electronic-file-transmission> on September 16, 2013.

²⁵ We did not use DMDC's match files from the August 2012 Medicaid Interstate Match. Using DMDC match files from that period would not have allowed sufficient time for States to verify the matches.

- the percentage of beneficiaries from the August 2011 match whose benefits were discontinued because their State determined that they were ineligible to receive Medicaid benefits in the State.

We were unable to project the total amount of improper Medicaid payments made and recovered by States because States reported improper payments for only a limited number of matches. Therefore, our findings are limited to presenting the actual amounts of improper payments and of recoveries that States reported making based on our sample of 300 matches from the August 2011 match.

To identify issues that States encounter when verifying matches, we asked States to explain their reasons for not verifying each beneficiary's Medicaid eligibility in our sample. We analyzed their responses and described the reasons States did not verify the eligibility of the beneficiaries.

Structured Interviews With CMS Officials. We conducted structured interviews with CMS officials to determine the extent to which they provided guidance to States, beyond the SMDL, for participating in the Medicaid Interstate Match. We asked them to describe any guidance that they provided to States related to participating in the match, and we analyzed their responses.

State Medicaid Agency Survey. We administered an electronic survey to Medicaid agency staff in all States to determine, for each of the four steps listed on pages 3–4, the extent to which they (1) have policies and procedures (policies), (2) experience barriers, and (3) receive guidance from CMS. If States reported that they had policies for any of the four steps, we asked them to provide their policies to us. We reviewed the policies to validate States' responses and determined the number of States that had policies for each step. We asked States to describe any barriers they experienced for each of the four steps, and we analyzed their responses to determine the type of any such barriers. We asked States what type of additional guidance, if any, they would like to receive related to the Medicaid Interstate Match. We analyzed survey responses to calculate the number of States that wanted to receive such guidance and to determine the types of such guidance.

We asked States to provide us with copies of their amendment to their Medicaid State plan that documents their participation in PARIS. We calculated the number of States that submitted such an amendment. We reviewed the amendments to determine the extent to which States addressed one or more steps related to participating in the Medicaid Interstate Match.

To determine whether States submitted Medicaid enrollment data for all of their beneficiaries, we asked each State to provide us with (for the August 2011 match) (1) the total number of beneficiaries enrolled in its State Medicaid program and (2) the total number of such beneficiaries for whom it submitted enrollment data for the match. To determine how many States did not submit enrollment data for all of their beneficiaries, we took the total number of beneficiaries enrolled in each State's Medicaid program and subtracted the total number of beneficiaries for whom the State submitted data for the match.

We received survey responses from all States.

Limitations

We did not determine the validity of the matches from the August 2011 Medicaid Interstate Match. Our analysis of the survey of State Medicaid agencies and the information we gathered on our sample of matches is based on self-reported data as of November 2012. We did not independently verify the accuracy of the survey data. We could not determine States' full compliance with the SSA because neither the SSA nor CMS guidance defines the meaning of "participation" as it relates to the Medicaid Interstate Match.

Standards

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

FINDINGS

States' participation in the Medicaid Interstate Match is limited

State participation in the Medicaid Interstate Match is required as a condition of receiving Medicaid funding for automated data systems. This match has the potential to identify beneficiaries who may be enrolled in multiple State Medicaid programs and thus to enable States to reduce improper payments. In analyzing how States perform the four steps to reduce improper payments through the match, we found that States' participation in the August 2011 match was limited. Specifically, States did not (1) submit Medicaid enrollment data for all beneficiaries; (2) verify more than half the matches (to determine beneficiaries' Medicaid eligibility); (3) discontinue beneficiaries' benefits for over half the verified matches; or (4) recover any improper payments.

Fourteen States did not submit Medicaid enrollment data for all beneficiaries in their State; five States reported that barriers related to resources or technical capability limited their ability to submit Medicaid enrollment data

While all States submitted Medicaid enrollment data for the August 2011 match, 14 States did not submit enrollment data for all of their beneficiaries. These 14 States did not submit between 1 and 85 percent—with an average of 46 percent and a median of 11 percent—of the Medicaid enrollment data for their beneficiaries. For example, one State did not submit enrollment data for 79 percent of its Medicaid beneficiaries (7 million of 9 million).²⁶ Another State did not submit enrollment data for 66 percent of its beneficiaries (650,000 of 988,000). To maximize the potential for the Medicaid Interstate Match to identify beneficiaries who may be enrolled in multiple State Medicaid programs, each State needs to submit complete enrollment data for all of its beneficiaries.

Among the 14 States that did not submit Medicaid enrollment data for all of their beneficiaries, 5 States reported that barriers related to resources or to technical capability limited their ability to submit data to DMDC. For example, one State Medicaid agency reported that it lacked staff to prepare the enrollment data for submission. Another State reported that it does not submit enrollment data from one of its two Medicaid enrollment systems because the system does not have the technical capability to display information that it receives from DMDC.

²⁶ Medicaid enrollment figures provided by the State are rounded.

States did not verify almost 70 percent of the matches because of issues with the enrollment data

States did not verify 68 percent of the matches from the August 2011 match because issues with the enrollment data led States to determine that the matches no longer merited verification. The most common reason that States did not verify matches was that States submitted enrollment data for beneficiaries who were no longer enrolled in—or soon to be no longer enrolled in—their Medicaid programs. The second most common reason that States did not verify matches was that States submitted incomplete or inaccurate enrollment data (e.g., incorrect SSNs).

With regard to the matches that were not verified, States did not verify 56 percent of those because the Medicaid eligibility dates for the beneficiaries indicated that they were no longer enrolled in—or would soon no longer be enrolled in—the program for at least one of the States for which there was a match. When a State submits Medicaid eligibility dates that indicate that the beneficiary is no longer enrolled in its Medicaid program, it can create a “false positive” match. When another State examines this match and finds that the eligibility dates indicate that the beneficiary will soon no longer be enrolled in at least one of the States’ Medicaid programs, that State may conclude that the match does not merit the resources for verification.

Of the matches that were not verified, States did not verify 17 percent of those because the match was associated with incomplete or inaccurate Medicaid eligibility dates or inaccurate SSNs. When a State submits incomplete or inaccurate eligibility dates for beneficiaries who are included on the match file, it is difficult for other States to determine whether such beneficiaries have an overlapping Medicaid coverage period. States must then conduct resource-intensive followup activities, which may include obtaining additional information from other States. Therefore, given their limited information and resources, States may conclude that these matches also do not merit verification. One State said: “When the data is not accurate or reliable, [conducting verification] is not an efficient use of [State Medicaid agency] staff time.”

Less than half the verified matches resulted in States’ discontinuing beneficiaries’ benefits

States reduce improper payments through participation in the Medicaid Interstate Match when one or more States discontinue the Medicaid benefits of beneficiaries who are found to be enrolled in multiple State Medicaid programs. While States verified 32 percent of the matches from the August 2011 match, only 41 percent of those matches resulted in a discontinuation of benefits. Forty-nine percent of the matches verified did

not result in a discontinuation of benefits because they were verified by only one of the States in which the beneficiary was enrolled, and that State was not the one that needed to discontinue benefits.²⁷ For the process to accurately identify beneficiaries who are improperly enrolled in multiple State Medicaid programs, *each* State that is flagged in a given match must verify the match to determine whether it needs to discontinue the beneficiary's benefits.

See Appendix B for the number of projected matches for the August 2011 match that are associated with the above percentages for verified and unverified matches.

States did not recover any improper Medicaid payments

To maximize the potential for reducing improper payments through participation in the Medicaid Interstate Match, States may recover improper payments made on behalf of beneficiaries found to be ineligible. For 41 percent of the verified matches from the August 2011 match that resulted in a discontinuation of benefits, States had made improper payments on behalf of beneficiaries. However, States provided the *amount* of improper payments for only 18 percent of these matches,²⁸ which totaled \$6,200 in improper Medicaid payments. Although this amount is small, we do not know the amount of improper payments for the other 82 percent of the verified matches that resulted in a discontinuation of benefits. Furthermore, all of the beneficiaries associated with the \$6,200 in improper payments were enrolled in Medicaid managed care programs. States reported that in these cases, they did not recover any improper payments from the managed care organizations because of barriers such as lack of resources and length of time needed to recover improper payments. This suggests that if the States had *not* discontinued these beneficiaries' benefits, they potentially would have made *additional* unrecoverable improper payments.

CMS guidance to States for participating in the Medicaid Interstate Match is limited; States reported that they needed more guidance

In June 2010, CMS issued an SMDL to provide guidance to State Medicaid agencies on complying with the SSA's requirement that States participate in PARIS. The guidance requires States to amend their respective Medicaid State plans to document their participation in PARIS,

²⁷ For 10 percent of the matches that were verified, States did not provide us with information to determine whether the beneficiaries' Medicaid benefits were discontinued.

²⁸ States did not provide the amounts of improper payments for enough matches to project the total amount of improper payments for the August 2011 match.

but it does not address any of the four steps related to reducing improper payments through participation in the Medicaid Interstate Match. In the absence of specific guidance, only four States have amended their respective State plans to include language that addresses one or more of the four steps.²⁹

Twenty-two of the fifty-two States reported they would like additional guidance related to one or more of the steps for participating in the Medicaid Interstate Match. See Table 1 for each step and the corresponding number of States that would like additional guidance.

Table 1. Number of States That Would Like To Receive Guidance Regarding Steps Related to Participation in the Medicaid Interstate Match

Step Related to Participation in the Medicaid Interstate Match	Number of States That Would Like To Receive Guidance Regarding Step
Submitting Medicaid enrollment data	7
Verifying matches	20
Discontinuing benefits	22
Recovering improper payments	21

Source: OIG analysis of survey data, 2013.

Note: Categories are not mutually exclusive. Therefore, the total number of States exceeds 52.

Most States had policies addressing at least one of the steps for participating in the Medicaid Interstate Match

Thirty-four of the fifty-two States had policies addressing at least one of the steps to reduce improper payments through participation in the Medicaid Interstate Match. Nine of those States had policies related to all four steps. Almost half of all States had policies on submitting Medicaid enrollment data. More than half of all States had policies on verifying matches, and more than a third of all States had policies on discontinuing benefits and policies on recovering improper payments. See Table 2 for the number of States that had policies addressing each of the four steps for participating in the match.

²⁹ In addition, CMS guidance did not set a deadline for States to amend their respective Medicaid State Plans. In the absence of such a deadline, 15 States had not amended their plans as of November 2012.

Table 2. Number of States That Have Policies Regarding Steps Related to the Medicaid Interstate Match

Step Related to Participation in the Medicaid Interstate Match	Number of States With Policies Regarding Step
Submitting Medicaid enrollment data	25
Verifying matches	27
Discontinuing benefits	19
Recovering improper payments	20

Source: OIG analysis of PARIS policies, 2013.

Note: Categories are not mutually exclusive. Therefore, the total number of States exceeds 52.

CONCLUSION AND RECOMMENDATION

State participation in the Medicaid Interstate Match is required unless PARIS is succeeded by a system that provides for data matching to identify beneficiaries who may be enrolled in multiple State Medicaid programs. As of the date of this report, there is no such successor system. The match provides States with an opportunity to reduce improper Medicaid payments. However, State participation in the match is limited. States do not consistently perform all four steps to reduce improper payments. Furthermore, CMS guidance does not define the meaning of “participation” as it relates to the match.

For States to receive the full benefit of their participation in the Medicaid Interstate Match, CMS needs to provide additional guidance to States that helps maximize the match’s potential to accurately identify beneficiaries who are enrolled in multiple States. States did not verify the majority of matches from the August 2011 match because they concluded that these matches did not merit verification. Guidance to States that helps improve the accuracy of the matches would likely increase the usefulness of the match. Until a successor system exists for PARIS, we recommend that CMS:

Issue Guidance to States on the Requirement for Participating in the Medicaid Interstate Match

Guidance from CMS could assist States in complying with the requirement for participating in the Medicaid Interstate Match. This guidance also could help States receive the full benefit of their participation. Until PARIS is succeeded by another system, CMS should define the meaning of “participation” in the match by establishing clear expectations for the actions that States should take to comply with the requirement. CMS should then issue guidance to States on its expectations for State participation in the match. In addition to assisting States in achieving compliance, guidance would also help ensure that States develop consistent policies regarding the match.

CMS guidance should address the following steps:

Submitting Medicaid Enrollment Data to DMDC. Guidance for submitting enrollment data should clarify whether States should submit Medicaid enrollment data for all of their beneficiaries. Guidance that requires States to do so would maximize the potential of the match to identify all beneficiaries who may be enrolled in multiple State Medicaid programs. Guidance also should clarify what data States should submit for the match. Submitting consistent, accurate, and complete enrollment

data for the match could potentially (1) generate the most accurate matches and (2) reduce the amount of time needed to verify matches.

Verifying Matches Identified by the Medicaid Interstate Match. After CMS issues guidance for the submission of Medicaid enrollment data, it should issue guidance requiring States to verify matches to determine beneficiaries' Medicaid eligibility. CMS could also provide guidance to States on how to track match-related activities and timelines for verifying matches. This type of guidance could result in the prompt verification and discontinuation of Medicaid benefits, which could reduce the length of time when beneficiaries are enrolled in multiple State Medicaid programs and thus ultimately reduce the amount of improper payments.

Discontinuing Benefits and Recovering Improper Payments. Although States vary in their systems and processes for discontinuing benefits and recovering improper payments, CMS could gather information from States regarding their best practices for these tasks. Working with States to develop guidance may result in fewer improper payments and/or in more money being returned to Federal and State governments. As appropriate, CMS could include the best-practices information in its guidance to States on these topics. CMS could also collaborate with ACF to provide additional guidance through the PARIS Web site and annual conference.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendation that it issue guidance to States on the requirement for participating in the Medicaid Interstate Match.

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

APPENDIX A

Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Matches that States did not verify primarily because of barriers with the Medicaid enrollment data	300 matches	68%	62.3%–73.0%
Matches that were not verified because the Medicaid eligibility dates on the match file indicated that the beneficiary was no longer enrolled or would soon no longer be enrolled in the Medicaid program for at least one of the States for which there was a match	203 matches that were not verified	56%	49.2%–63.0%
Matches that were not verified because the match was associated with missing or inaccurate Medicaid eligibility dates or inaccurate SSNs	203 matches that were not verified	18%	12.0%–23.0%
Matches that States verified	300 matches	32%	27.0%–37.7%
Matches that did not result in a discontinuation of benefits because they were verified by only one of the States in which the beneficiary was enrolled	97 matches that were verified	49%	38.3%–59.0%
Matches that resulted in a discontinuation of benefits	97 matches that were verified	41%	31.3%–51.2%

Source: OIG analysis of match data, 2013.

APPENDIX B

Number of Projected Matches for the August 2011 Medicaid Interstate Match

Estimate Description	Projected Number of Matches (n=159,964)	Number of Matches from the Sample (n=300)
Matches that States did not verify	108,776	203
Matches that were not verified because the Medicaid eligibility dates on the match file indicated that the beneficiary was no longer enrolled or would soon no longer be enrolled in the Medicaid program for at least one of the States for which there was a match	60,915	203
Matches that were not verified because the match was associated with incomplete or inaccurate Medicaid eligibility dates or inaccurate SSNs	18,492	203
Matches States verified	51,189	97
Matches that did not result in a discontinuation of benefits because they were verified by only one of the States in which the beneficiary was enrolled	25,082	47
Matches that resulted in a discontinuation of benefits	20,987	40

Source: OIG analysis of match data, 2013.

APPENDIX C

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 11 2014

TO: Daniel R. Levinson
Inspector General

FROM: ~~Marilyn Tavenner~~ */S/*
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Public Assistance Reporting Information System: State Participation in the Medicaid Interstate Match is Limited" (OEI-09-11-00780)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-referenced OIG draft report. OIG's report focuses on states' participation in the Medicaid Interstate Match. This is a tool used to reduce improper Medicaid payments, made as a result of one type of eligibility error, by identifying beneficiaries who are enrolled in multiple state Medicaid programs. The findings and recommendations focus primarily on states' use of the tool, rather than on actual eligibility errors resulting from states' failure to use it.

The report did find that, in its sample from August 2011, states did make improper payments for beneficiaries for whom interstate matches (i.e., evidence that the beneficiary was enrolled in more than one state) ultimately resulted in a discontinuation of benefits. However, states only provided the amount of improper payments for 18 percent of these matches, which totaled \$6,200 in improper Medicaid payments.

The report does not seem to have enough information to adequately determine the real scope of eligibility errors resulting from inadequate use of the Medicaid Interstate Match; but, based on its findings, OIG did conclude that states' participation is limited and that states need more guidance from CMS about such participation.

OIG Recommendation

The OIG recommends that CMS issue guidance to states on the requirement for participating in the Medicaid Interstate Match.

CMS Response

The CMS concurs with OIG's recommendation that CMS issue further guidance to states to clarify the requirement for participating in the Medicaid Interstate Match.

Agency Comments (continued)

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Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

China Tantameng served as the team leader for this study, and Veronica Gonzalez served as the lead analyst. Other Office of Evaluation and Inspections staff from the San Francisco regional office who conducted the study include Christina Lester and Tiffany Stanley. Central office staff who provided support include Clarence Arnold, Kevin Manley, and Christine Moritz.

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