Douglas Porter:

Thank you Mr. Chairman, members of the committee, for this opportunity to testify. For the record, my name is Doug Porter, director of the Washington State Health Care Authority and I'm here to talk about state and federal efforts to reduce fraud, waste and abuse in the Medicaid program. And specifically I'll speak to the state's perspective on what's working, what's not working, and where we see room for improvement.

What's working?

I'm happy to report that the partnership between the state and federal officials, in the program integrity is a good one. Our interests and incentives to be good stewards of the taxpayers' money are closely aligned. I'll cite just a few examples of this solid working partnership.

I've been associated with the Medicaid program for about twenty years or so and I've served on various technical advisory groups. In my opinion, the fraud, abuse and technical advisory group is one of the most productive and best functioning…in recent memory – a solid collaboration between state and federal officials.

As Dr. Budetti just mentioned, the Medicaid Integrity Institute is a huge new asset for state program integrity staff to develop skills and share best practices.And we welcome the openness on the part of CMS to make available Medicare data to states. We think this is a big opportunity not only for program integrity enhancements, but also to improve care coordination for those clients who are eligible for both Medicare and Medicaid.

What's not working?

Three major challenges on that front. The erosion recently of state resources, the layers of outmoded or ineffective programs that we've had to contend with, and bad data. The erosion of state resources, I'll give you my own personal story over the last four years, since 2008. I've lost 20 percent of my workforce due to budget cuts. The legislature much prefers to eliminate administrative costs rather than program costs. I now have only 40 staff assigned to program integrity efforts to oversee over 5 billion dollars a year of health care expenditures. That's just not enough resource to do the job right.

On the continuance of ineffective programs, I would list, as you've already heard, the Medicaid Integrity contractors are mixed; Medicaid eligibility quality control, or MEQC; payment error rate measurement program, or PERM; and the Medicare/Medicaid data match project. These programs all draw resources away from activities that, in our state would yield a better return on investment, and detract from our ability to generate even more savings than we have to date.

On the data front, there's a lot of data and very little good information, as Dr. Budetti just indicated. Poorly collected and poorly analyzed data is what's giving us the problem. The Medicaid Statistical Information System is not uniformly reported on by all states, making apples to apples comparisons very difficult.

And the Medicare data we are getting access to to date has been difficult as it comes, Medicare, part A, B and C comes in 6 different file formats for both ongoing and historic data, and it makes it very, very difficult, if not impossible, to merge with our existing Medicaid database.

Opportunities for improvements.

Let's build on what works. I would like to suggest that the state efforts be supported and recommend that a 75/25 matching fund be available to state program integrity staff, such is currently available to Medicaid fraud control units around the country.

Also, if we could do one thing that I think would take a big burden off states, (it) is to create a national level provider enrollment capacity that would screen out bad providers on the front end, and in the process of getting a national provider identification number, that would be a start. And then have them re-enroll every three years. That way a central observation could be made on the databases that currently exist as to who the bad actors are out there.

I think the Medicare databases I said could be improved by having a single documented file format and one single set of confidentiality and privacy requirements. And we should use a return on investment analysis to evaluate the effectiveness of programs and fund them accordingly.

I would make a pitch, finally, to further enhance the Medicaid Integrity Institute by using distance education involving webinars to reach more state staff around the country. And I would suggest the establishment of a national certification process to credential state program integrity staff.

That concludes my prepared remarks, I thank you very much for the opportunity to be here today and I'd be glad to answer any of your questions.