MACPAC

Measuring Performance and Return on Investment for Program Integrity Strategies

Medicaid and CHIP Payment and Access Commission

Jessica Morris

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Overview

- Background and methods
- MACPAC study
- Findings
- Next steps

Medicaid program integrity

- Federal and state agencies pursue a variety of strategies to address fraud, waste, and abuse
- Some are embedded in programmatic functions (e.g. provider enrollment) or conducted in a separate program integrity function (e.g. audits)
- Multiple PI requirements have been added to statute and regulation

Commission focus on effectiveness

- MACPAC has examined PI previously and raised concerns about the effectiveness of PI activities and made recommendations
- March 2012:
  - Eliminate redundant and outdated PI programs
  - Determine which are most effective, and develop methods for quantifying the effectiveness of different strategies
  - Assess tools for detecting and deterring fraud and abuse; promote use of tools that are most effective
- June 2017: Reiterated these recommendations in a chapter on PI in managed care

MACPAC study

- Contract with Myers and Stauffer designed to:
  - collect information on how states calculate performance or ROI from a number of PI approaches
  - identify which performance measures or data are necessary to quantify results for each approach
  - identify state challenges and successes in measuring ROI
- Environmental scan to identify 10 PI approaches
- Interviews with CMS, subject matter experts, and officials in 8 states: Florida, Illinois, Kentucky, New Mexico, Ohio, Utah, Virginia, and Wyoming

Return on investment

- We chose ROI because it's a performance measure that can identify which activities are high value
  - As a ratio it simplifies differences among states and approaches, and allows direct comparison
  - Measures gain or loss relative to an investment
  - Measured by the return from cost recoveries and cost avoidance relative to the cost of the approach (e.g. staff or contractor time, systems investments)

PI approaches included in study

- Data mining (to detect providers to be audited)
- Electronic visit verification (EVV)
- Provider enrollment
- Recovery Audit Contractors (RAC)
- Unified Program Information Contractor (UPIC)
- Provider self-audits
- Public Assistance Reporting Information System (PARIS)
- Lock-in programs
- Prior authorization
- Third-party liability (TPL) and estate recovery

Data Mining

- Used to audit suspicious providers found from outliers or high-risk areas in payment data
- ROI from recoveries and cost avoidance: uncovering potential overutilization, refining a targeted analysis
- Some states allow extrapolation of a statistically valid sample of claims to the universe of claims in the state

EVV

- Ensure caregivers are present; billed services were rendered, streamline paper work, reduce duplicate records
- ROI from cost savings through claims denials and cost avoidance (prosecutions, terminations, restitutions)
- States in varying stages of implementation

Provider Enrollment

- Process to identify high-risk providers prior to providing Medicaid services
- Providers consent to criminal background checks and fingerprinting
- ROI from
  - cost avoidance with continuous provider enrollment, reducing administrative costs from reenrollment
  - cost recoveries when providers were terminated and a settlement via fine was paid to the state

RACs

- States required to procure contractors to review claims, identify improper payments, collect recoveries from overpayments, and identify underpayments
- Vendors reimbursed on a contingency fee basis, but find some state programs unsustainable
- States have waivers of RAC requirements
  - State inability to procure a contractor
  - A relatively low number of FFS claims for review

UPICs

- Regional CMS contract to audit Medicare, DME, home health, hospice, and Medicaid; paid for costs plus fee
- States often perceived the CMS UPIC program as duplicative with the RAC program
- Too soon to assess ROI but anticipate future comparisons to RAC

Provider self-audits

- Investigations performed by provider
- Typically initiated when the provider identifies inappropriately paid claims but not fraud or abuse
- ROI from overpayment recoveries or claims adjustments; cost avoidance from clarification to billing policies

PARIS

- PARIS matches data from public programs, with federal and state data to ensure appropriate enrollment and retention in public programs
- ROI from cost recoveries or cost avoidance with duplicate enrollment or overlapping services
- State concerns about the reliability of the data or being overwhelmed with following up on matched data and determining its validity

Lock-in programs

- Assigns beneficiary to a single provider in order to control utilization, monitor services, curb drug-seeking behavior
- ROI from cost avoidance with decreases in unnecessary prescriptions, ancillary tests, and hospital, physician/ED claims

Prior authorization

- To varying degrees, states opt to conduct prior authorization for specific services
  - e.g. prescriptions, non-emergency transportation, inpatient and outpatient hospital services, behavioral health services, private duty nursing, adult day care, DME, or other medically necessary services
- ROI from cost avoidance with denied claims for unnecessary services
- Recoveries can also occur through a retrospective review of paid claims

TPL and estate recovery

- All states required to pursue third-party payers to reduce Medicaid payments
  - Recoveries from private insurance, Medicare, worker's compensation, veterans' benefits, and court settlements
  - TPL cost avoidance is required on CMS-64
- States required to recover some costs for care from estates of beneficiaries over age 55, admitted to a facility/after death

Study findings

- The goal was to determine the ROI of various PI efforts; which are most effective in detecting and deterring fraud and abuse
- We were unable to collect ROI information on most PI strategies due to a number of challenges states face
  - This supports prior MACPAC findings and shows earlier recommendations remain relevant
- Several issues identified may merit further consideration and potential recommendations

Many states did not or could not calculate ROI for PI activities

- ROI is most easily calculated when there are clearly identifiable resources used to conduct the activity and the results include actual recoveries
- Cost recoveries can be directly measured but there are different ways to measure cost avoidance
- There are no parameters for calculating cost avoidance in Medicaid
- PI activities do not exist independently, making it difficult for states to attribute costs or allocate recoveries to particular interventions

Other limitations

- States often develop their own metrics that then can't be used for cross-state comparison
- States may not invest in tracking the results or calculating ROI for federally mandated activities
- Many PI activities have non-quantifiable benefits that can't be factored into ROI calculations but measure beneficiary outcomes

Opportunities to improve

- States are still working to improve connections between FFS and managed care PI efforts
  - Return on PI was limited because managed care was excluded from the review or encounter data were inaccurate and incomplete
- States that are unable to secure RAC vendors have been able to obtain waivers from CMS
- States continue to seek CMS guidance

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