Chapter 3:

Improving the Effectiveness of Medicaid Program Integrity

Improving the Effectiveness of Medicaid Program Integrity

Recommendations

3.1 The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.

3.2 To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

Key Points

- Medicaid program integrity (PI) activities aim to ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care and preventing and detecting fraud, waste, and abuse.
- State Medicaid programs have primary responsibility for PI, which includes activities spanning a continuum from front-end controls to recoupment. PI activities may also be embedded in other programmatic functions.
- MACPAC has repeatedly commented on the need to identify high-value PI activities; in this report, we share findings from our efforts to collect information from states on how they measure PI performance and return on investment (ROI).
- The Commission found that states have little incentive to calculate ROI because many PI activities are federally required, embedded in broader program functions, or generate benefits that are not easily quantifiable.
- States must make choices about which optional activities to invest in and how to structure required activities, but they have little information about what works in Medicaid upon which to base their decisions.
- It is the Commission's view that the federal government is in the best position to take the lead in identifying features that make PI approaches successful and in disseminating this information to states. The Secretary should use his authority to conduct a rigorous examination of current activities and conduct pilots to test new strategies or improvements to existing strategies.
- Because the recovery audit contractor (RAC) program—mandatory in Medicaid—has not been effective in all states, MACPAC recommends that Congress change the statute to make participation in the RAC program optional. This would be a step forward in ensuring that PI efforts are efficient and do not place an undue burden on states or providers.

CHAPTER 3: Improving the Effectiveness of Medicaid Program Integrity

Medicaid program integrity (PI) activities are meant to ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care and to prevent and detect fraud, waste, and abuse. State Medicaid programs have primary responsibility for PI, which includes a wide range of activities—dedicated PI activities as well as those embedded in other program functions (such as individual and provider enrollment, service delivery, and payment). The Centers for Medicare & Medicaid Services (CMS) provides a regulatory framework for the Medicaid Integrity Program, conducts routine oversight, and provides technical assistance to state Medicaid programs. However, CMS has not focused efforts on helping states understand which state-level policy design and implementation approaches lead to successful PI outcomes. Thus, although there is widespread agreement that states should focus their PI resources on areas of risk and invest in approaches known to be effective, they have little guidance on where or how to focus (GAO 2015).

Over time, multiple requirements for what states must do to reduce fraud, waste, and abuse have been added to statute and regulation. States must make their own choices about how to invest limited resources, for staff and contractors with legal, clinical, audit, or data expertise, and for tools such as data analytics. However, they have little information on which optional approaches lead to successful Medicaid PI activities. Moreover, there may be perceived advantages to pursuing approaches that are mandated or that result in postpayment recoveries, but there is no clear method for ascertaining which approaches are the most efficient application of resources.

In 2018, building on past work aimed at improving the effectiveness of state Medicaid PI activities, the Commission collected information from states on how they measure performance and return on investment (ROI) from a number of PI approaches, which could in turn help to identify high-value activities across the Medicaid program. The study findings were inconclusive for a number of reasons:

- states have little incentive to calculate ROI for many activities;
- states could not estimate the costs associated with PI activities embedded in broader program functions; and
- some PI activities generate benefits (such as a reduction in patient harm) that are not easily or readily quantifiable.

In 2012, and again in 2017, the Commission recommended that "CMS should enhance states' abilities to detect and deter fraud and abuse by developing methods for better quantifying the effectiveness of program integrity activities, by improving dissemination of best practices in program integrity, and by enhancing program integrity training programs" (MACPAC 2017, 2012). The Commission's recent study, however, shows that little action has been taken. For example, we found multiple concerns regarding statutory requirements that states contract with a recovery audit contractor (RAC). Many states have been unable to procure a RAC, forcing them to seek waivers from CMS. Other states are finding diminishing returns from RAC contracts, which also overlap with newer postpayment review activities.

As we have noted in prior reports, states must continually strike a balance between pursuing effective PI strategies and addressing other program goals, particularly ensuring access to a sufficient network of providers and efficiently administering multiple components of a complex program (MACPAC 2012). The federal government is in the best position to collect information across

states to identify the features that make specific approaches successful, especially those mandated by statute.

Given the inconclusive findings of our study, the Commission makes two recommendations aimed at improving the effectiveness of state PI activities:

- The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.
- To provide states with flexibility in choosing PI strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act (the Act) to make the requirement that states establish a RAC program optional.

Background on Medicaid Program Integrity Activities

The federal government has the responsibility to protect the integrity of the Medicaid program by "providing effective support and assistance to states to combat provider fraud and abuse" (§ 1936 of the Act). CMS currently supports state Medicaid integrity efforts by defining in regulation the parameters for how states must address statutory requirements and conducting oversight to ensure compliance. CMS also provides educational opportunities, such as the Medicaid Integrity Institute. In addition, it provides one-on-one technical assistance to states (CMS 2016). These activities are worthwhile at the state level, but the benefits are not transferrable to other states.

State agencies have a number of tools to identify and address fraud, waste, and abuse in Medicaid, some of which are statutorily required and some of which are optional. PI activities span a continuum from front-end controls to recoupments, and corrective actions related to these activities may be embedded in other programmatic functions (e.g., eligibility determination, provider screening and enrollment, claims payment, and managed care oversight). Other PI activities are undertaken primarily to ensure that public dollars are appropriately spent (e.g., prepayment and postpayment reviews and audits) (Table 3-1).

TABLE 3-1. Continuum of State Medicaid Program Integrity Activities

Medicaid payments	Program integrity activities
Beneficiary enrollment	• Determine eligibility • Collect third-party liability (TPL) information and coordinate benefits • Verify reported information • Check the Public Assistance Reporting Information System to verify that beneficiaries are not receiving duplicate federal and state benefits • Conduct monitoring and auditing activities • Conduct Medicaid Eligibility Quality Control and Payment Error Rate Measurement (PERM) eligibility reviews
Provider enrollment	• Screen and enroll eligible providers, reenroll providers, and revalidate providers • Check exclusion lists and other verification databases in accordance with state and federal screening requirements

TABLE 3-1. (continued)

Medicaid payments	Program integrity activities
Provider enrollment	• Ensure appropriate disclosures are reported by providers and fiscal agents • Implement moratoria on providers when federally approved or mandated • Report any adverse provider application actions to the U.S. Department of Health and Human Services Office of Inspector General
Service delivery	• Develop and document coverage, billing, and payment policies • Lock in certain beneficiaries to certain providers or pharmacies to prevent so-called pharmacy or doctor shopping • Develop program integrity provisions for managed care contracts • Verify receipt of service using electronic visit verification • Review prior authorization requests consistent with state policy • Review prospective drug utilization review requests
Payment	• Develop, implement, and evaluate prepayment edits and audits • Apply TPL information • Use predictive modeling and other advanced data analytics to flag potential errors • Suspend payments to providers based on credible allegations of fraud • Adjudicate final payments • Issue explanation of benefits statements • Submit claims for federal matching funds
Postpayment review	• Create and implement methods and criteria for identifying suspected fraud cases • Conduct preliminary or full investigation on referrals of fraud or abuse • Establish and maintain a timely beneficiary verification procedure • Refer suspected fraud to law enforcement and collaborate with fraud investigations • Coordinate with Medicaid Fraud Control Unit and assist with prosecutions • Participate in federal PERM fee-for-service and managed care reviews • Pursue third-party payments when available • Perform retrospective reviews of care • Conduct surveillance and utilization reviews • Audit payments or ask providers to conduct self-audits • Support federal Unified Program Integrity Contractor audits • Procure and support recovery audit contractors • Supply data for Medicare-Medicaid matches and process results
Reporting and follow-up	• Terminate fraudulent providers and contracts and report such actions to appropriate parties • Recoup overpayments from providers • Return federal share of overpayments • Calculate return on investment • Compile program integrity statistics • Calculate and report payment suspensions due to credible allegations of fraud • Participate in state program integrity reviews (focused and desk reviews) • Identify and implement corrective actions and sanctions • Oversee managed care organization program integrity contract compliance • Report the identification and collection of overpayments due to waste, fraud, and abuse • Report annually the use of payment suspensions based on credible allegations of fraud • Report administrative expenses associated with program integrity activities

Sources: MACPAC, 2018, analysis of state Medicaid program integrity activities.

MACPAC Study on State PI Performance

In 2018, the Commission collected information from states on how they measure performance and ROI from a number of PI approaches. We reviewed state and federal agency websites, annual reports, and oversight reports as well as relevant laws, regulations, and policies. We conducted interviews with CMS, subject matter experts, and officials in eight states: Florida, Illinois, Kentucky, New Mexico, Ohio, Utah, Virginia, and Wyoming. We also held a listening session with a number of states in the spring of 2018 to get additional insights on the challenges and successes associated with Medicaid PI.

There are many ways to assess program performance, but we used ROI because it measures the return from both cost recovery and cost avoidance relative to the investment in the approach. As a ratio, ROI simplifies differences across states and approaches, and it allows direct comparison among states. To calculate cost recovery, states add up recovered payments, for example, overpayments or erroneous payments to providers or managed care organizations (MCOs) for previously paid claims or capitation payments. To calculate cost avoidance, states determine savings from payments avoided or administrative actions prevented, for example, prepayment reviews, provider termination, program suspensions, or when inappropriate or medically unnecessary services are restricted or avoided.

We found from our study that states face challenges in assessing their performance and lack the information needed to identify effective state PI activities, including those that are statutorily required. Many states do not quantify the effectiveness of various approaches, such as by calculating an ROI, for a variety of reasons. States, therefore, have little information on the relative value of their current PI activities, which can result in misapplication of their limited resources. Nevertheless, they have expressed interest in additional information on the policy design and implementation features that lead to success across the broad spectrum of PI approaches available.

Approaches studied

We selected 10 state approaches to PI based on a review of publicly available documentation on implementation and operation within the state; documentation on cost avoidance, cost recovery, or other ROI measures; and the extent to which the state had some experience with the approach (Table 3-2).

Data mining. Suspicious patterns and aberrations found in payment data can be used to audit specific providers. Although data mining as a strategy is not federally mandated, it is one approach states may apply in meeting the mandate that all state Medicaid programs conduct postpayment reviews. Most states conduct data mining using state PI staff, a contractor, or a combination of the two, because it can be difficult to hire and retain state staff with sufficient knowledge to support advanced data modeling. Data mining may overlap with other postpayment review activities, such as the RAC program, provider audits, or audits of prior authorization activities.

Data mining analyses can be targeted toward specific items of interest, such as data outliers or high-risk areas, and targeted to specific types of data, including peer comparisons (to identify billing outliers); services provided after death (to identify services not rendered); duplicate payments (to identify potentially unnecessary services or services not rendered); and eligibility (to identify individuals ineligible for coverage). In addition, data mining is used to analyze both managed care and fee-for-service (FFS) claims, although not all states have access to accurate, usable encounter data. Such activities require not only data systems capable of storing and analyzing patterns of claims data but also personnel with statistical, medical, and investigative expertise.

The primary ROI measure for data mining is the amount of money recovered based on audits triggered by suspicious patterns, for instance,

recoveries from overutilization. Results may also lead to cost avoidance measures, such as state policy changes that result in fewer improper claims. Challenges states face in implementing data mining approaches include coming up with the resources for ensuring the validity of the statistical sampling, extrapolation, or analytic approach and for covering the legal expenses associated with defending demands for provider recoveries.

Electronic visit verification. As a PI strategy, electronic visit verification (EVV) is meant to ensure that services billed were rendered and to streamline paperwork and reduce duplication of records. Implementing EVV requires the use of data systems that allow providers to check in from the site of service by phone, through geographic positioning systems or mobile applications, or by other means.

The 21st Century Cures Act (P.L. 114-255) requires all states to implement EVV for certain services, beginning with personal care by 2020 and home health by 2023. PI staff, Medicaid or sister agency staff, MCO staff, or designated contractors may each have a role in EVV, depending on the state. States are currently in varying stages of EVV implementation, and most have not yet begun to report ROI for this approach.

States may ultimately be able to calculate cost avoidance and cost savings captured through two mechanisms. If the EVV system is linked to claims processing and adjudication systems on the front end, then a state can calculate cost avoidance and ROI for claims that are denied for failure to have a verified visit. If the EVV system is not linked to the claims system, then data can be used to identify services not rendered, which could result in the identification of and recoveries from overpayments.

Provider screening and enrollment. As a PI approach, provider screening and enrollment can identify questionable providers before they are allowed to provide Medicaid services. As a condition of enrollment, states must conduct criminal background checks, including fingerprinting, particularly if a provider is considered high risk, such as when they face a credible allegation of fraud, waste, or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid program within the previous 10 years. Providers that do not pass the background check cannot participate in the program.

Provider screening and enrollment can be conducted by the state or by a contractor on behalf of the state. Before 2016, providers participating in Medicaid managed care plans but not FFS did not have to enroll separately in the Medicaid program, but a final rule that went into effect that year (42 CFR 438) required all providers serving Medicaid beneficiaries to be enrolled with the state Medicaid agency by July 2018. In addition to preventing fraud and abuse, provider screening and enrollment supports functions such as monitoring to ensure there is a sufficient number of providers and services available in the geographic area.

Quantifying ROI for provider screening and enrollment is challenging because the primary ROI measure is cost avoidance. Some states have noted the difficulty of calculating savings associated with continuous provider screening and enrollment, which involves keeping good providers continually enrolled, reducing unnecessary administrative costs associated with reenrollment, and efficient verification processes. Some states report cost recoveries when providers are terminated and are fined by the state. However, there is no standard methodology for calculating ROI that captures the costs avoided with provider screening and enrollment, and states often lack the resources to develop their own.

Recovery audit contractors. In 2002, following successful efforts in several states, CMS issued guidance encouraging states to contract with vendors to examine Medicaid claims and pursue recovery from overpayments, third-party liability (TPL), credit balance collections, and other activities, to be compensated on a contingency basis (CMS 2011). In 2005, a three-year Medicare RAC demonstration began, which ultimately identified over $1 billion in overpayments and

underpayments. To build on the success of these individual state efforts and the Medicare experience, and to maximize the potential returns to the federal government, Congress included a provision in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) making RAC programs mandatory for all state Medicaid programs as of December 31, 2010.

States have some flexibility regarding the design, procurement, and operation of their RAC programs. CMS has established a maximum contingency rate from amounts recovered which may not exceed the contingency rate for a Medicare RAC: currently 12.5 percent for all services except durable medical equipment, which is 17.5 percent (CMS 2011). Federal regulations also require the Medicaid RAC to work with the state to develop an education and outreach program, which includes notifying providers of RAC audit policies and protocols. The RAC must notify providers of overpayment findings within 60 calendar days of identification and must refer suspected cases of fraud or abuse to the state in a timely manner, as defined by the state.

RACs, which often bear the risk of covering the program's up-front expenses before any recoveries are realized, increasingly find it difficult to maintain a sustainable program given that recoveries have been inconsistent and are declining. States have the authority to include managed care encounters in their RAC program. Many states with high managed care penetration have relatively few FFS claims, which limits a RAC vendor's ability to achieve profitable recovery amounts. As a result, states obtain waivers of some or all of the RAC requirements, or vendors limit the resources they invest, choose to not bid on a state's RAC program at all, or choose not to renew past engagements.

States can calculate the ROI for their RAC programs by balancing recoveries of overpayments identified by the vendor, collection of outstanding credit balances, and TPL recoveries against the investment required to implement RAC programs. States are required to report recoveries from their RAC programs on form CMS-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

Unified Program Integrity Contractors. CMS contracts with Unified Program Integrity Contractors (UPICs) to perform fraud, waste, and abuse detection, deterrence, and prevention activities (§ 1936 of the Act). CMS contracts with UPICs in five regions to perform PI activities associated with Medicare Parts A and B, durable medical equipment (DME), home health, hospice, and Medicaid claims. CMS's UPIC contractors are required to coordinate with each state in their region to identify and investigate providers.[1]

At the state level, UPICs may also act to ensure that inappropriate payments are prevented or recouped, whether related to billing for services not rendered, deliberate duplication of services, altering claims through up-coding or unbundling codes, kickbacks or rebates for patient referrals, and billing for non-covered services. The extent to which states participate is at the state's discretion.

States in our study cited initial challenges in working with UPICs, including state liability for the federal share of overpayments reported by the UPIC even if they are not recovered, a program requirement that could deter states from using UPICs altogether. States also expressed concerns that federal contractors had previously attempted to apply Medicare guidelines or other inappropriate benchmarks when analyzing Medicaid data rather than building knowledge of the state Medicaid policy. Lastly, states indicated that they see the CMS UPIC program as duplicative of the RAC program, even though UPICs have a wider scope that includes investigations of possible fraud (also involving Medicare), regional assignments, and greater access to data, and—unlike RACs—are paid on a cost-plus fee basis. Eventually, states may be able to calculate ROI for UPICs, but to date, they have minimal quantifiable evidence for this new program.

Provider self-audits. A provider may audit itself either at the state's request or because the provider identified an issue that warrants further investigation, such as an overpayment. In most

cases, self-audits are initiated when the provider identifies inappropriately paid claims that do not involve concerns of fraud or abuse. In doing so, they often avoid false claims penalties, which could include up to triple damages, investigative expenses, criminal penalties, and interest. When providers identify incorrect billing patterns or policies, corrective actions or procedures should lead to fewer incorrect payments, resulting in additional cost avoidance. Results of provider self-audits can also be used to identify other providers with similar problems or compliance concerns who can be further investigated through the program. States we interviewed indicated that provider self-audits are successful when the state has clear, well-supported policy guidelines that can be easily followed by the provider performing the self-audit.

States can calculate ROI for provider self-audits by balancing the costs of supporting provider self-audit activities against recoveries from overpayments and claims adjustments or cost avoidance resulting from clear and up-to-date billing policies and improved provider practices and education. None of the states we interviewed calculated ROI from provider self-audits.

Public Assistance Reporting Information System. Operated by the federal Administration for Children and Families, the Public Assistance Reporting Information System (PARIS) is a process that matches data from certain public programs to find beneficiaries who receive benefits in more than one state, receive duplicate federal and state benefits, or may be eligible for but are not enrolled in other programs, such as Medicaid or veterans' and military health programs. PARIS helps to ensure appropriate enrollment and retention in public programs and reduces the opportunity for improper payments.

Under the Qualifying Individual Program Supplemental Funding Act of 2008 (QIFA, P.L. 110-379), as of October 1, 2009, all states are required to submit data to PARIS as a condition of receiving federal funding for their Medicaid Management Information Systems (MMIS). States can use this information to evaluate past or continuing eligibility. However, while all states are required to submit data to PARIS and can generate an ROI when they avoid costs associated with duplicative enrollment such as overlapping services, they are not required to use the results to reduce the expenses of their own state programs.

Each state we interviewed indicated that it used PARIS results to varying degrees and some reported large recoveries. For example, states have found a positive return when using PARIS data to check on duplication of benefits with the Department of Veterans Affairs (VA). If a veteran is 70 percent to 100 percent service-connected disabled and receives care in a VA facility, the VA covers 100 percent of the costs. Surviving spouses and dependents of veterans who had a 100 percent service-connected disability receive comprehensive VA coverage, which pays 80 percent of all medical care (including skilled nursing care) and 100 percent of prescription drugs. When cases are identified, Medicaid can potentially recoup some of these funds retroactively (typically up to one year of costs can be recovered for retroactive eligibility) and might also be able to close these cases to avoid future unnecessary expenditures. Eligible veterans are often unaware that they can receive their full earned benefits with just two years of honorable service. A number of states have used PARIS data to identify Medicaid beneficiaries receiving long-term services and supports who were eligible for but not enrolled in veterans' benefits. Receipt of such benefits can also alleviate costs incurred to the veteran or spouse and reduce the chances of Medicaid estate recovery.[2]

Concerns expressed by states about PARIS had to do with not having enough staff to handle results or to verify data (necessitating hiring contractors), not trusting the validity of the data generally, and doubts about the accuracy and reliability of the matches. Thus, although all states are required to submit data to PARIS and can generate an ROI when they avoid costs associated with duplicate enrollment, if they do not use the system to generate savings on an ongoing basis, then ROI is difficult to calculate.

Lock-in programs. Beneficiary lock-in programs (also called restricted card programs) assign

certain Medicaid beneficiaries to specific providers or pharmacies to prevent so-called pharmacy or doctor shopping. Lock-in programs allow states to act when they identify patterns of service misuse by a beneficiary (e.g., shopping behavior), as well as when providers are billing inappropriately or not following standard medical practice. Although lock-in programs are not federally mandated, most states (including all those interviewed for our study) have at least one for pharmacy benefits. Implementing and operating these programs requires considerable resources, such as medical and legal professionals for review and appeals, as well as oversight throughout the lock-in period.

Several states we interviewed cited challenges in operating an effective lock-in program in a managed care environment. For example, the state must decide whether to maintain a centrally operated program or to allow MCOs to operate their own programs. Having multiple lock-in programs makes it challenging to prevent beneficiaries from changing plans to avoid restrictions.

Lock-in programs could be measured by the costs of the program and the cost avoidance associated with decreases in unnecessary prescriptions, ancillary tests, and claims for hospital, pharmacy, physicians, and emergency department visits. States cited challenges in measuring program performance because there is no consensus on the appropriate time period (pre- and post-lock-in period) to include when accounting for the savings.

Prior authorization. Services that often require prior authorization in Medicaid include non-emergency transportation, inpatient and outpatient hospital services, behavioral health services, private duty nursing, adult day care, and DME. States may opt to use prior authorization to help control utilization and avoid unnecessary procedures. Each state we interviewed noted that prior authorization is in place to some degree, but their policies vary as to which services and prescriptions must be authorized.

States may use contractors to conduct prior authorization reviews because the process can be human-resource intensive and would otherwise require staff with clinical knowledge, whom states have difficulty attracting and retaining. In FFS programs, the state often handles prior authorization through one contractor for medical services and a second contractor for pharmacy. Under managed care, each plan typically uses separate prior authorization contractors, each with its own internal processes, resulting in multiple contractors per MCO. This can be challenging for the MCO's providers, who must navigate the different contractors and processes to obtain authorization for services and prescriptions.

Prior authorization policies may lead to cost avoidance through denied claims for unnecessary services. Recoveries can also occur through a retrospective review of paid claims for services that were provided even though prior authorization was not obtained. However, the states we interviewed did not report on the ratio of costs avoided and costs recovered relative to their investments to determine whether there was a positive ROI for prior authorization.

Third-party liability and estate recovery. Federal statute requires states to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid beneficiaries (§ 1902(a)(25)(A) of the Act). Because Medicaid is generally the payer of last resort, TPL processes give state Medicaid agencies the ability to pursue third-party payers and thereby reduce Medicaid payments. States track recoveries of payments from private health or liability insurance, Medicare, worker's compensation, veterans' benefits, and court settlements. State Medicaid agencies are also required to recover the costs of providing care from the estate of any beneficiary over age 55 after the beneficiary either is admitted to a facility or after the beneficiary's death (§ 1917(b) of the Act).[3]

Compared to other state PI activities, states may find it easier to calculate ROI for TPL and estate recovery because they are required to track and report significant TPL and estate recoveries on the CMS-64. Therefore, states must dedicate staff to work on data collection and reporting.

TABLE 3-2. State Program Integrity Approaches: Mandatory versus Optional and Primary ROI Measure

Approach	Mandatory vs. optional and authorizing legislation	Primary ROI measure
Data mining	Optional	Cost recovery
Electronic visit verification	Mandatory per the 21st Century Cures Act (P.L. 114-255)	Cost recovery and cost avoidance
Provider screening and enrollment	Mandatory per the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)	Cost avoidance
Recovery audit contractors	Mandatory per the ACA	Cost recovery and cost avoidance
Unified Program Integrity Contractors	Optional	Cost recovery and cost avoidance
Provider self-audits	Optional	Cost recovery and cost avoidance
Public Assistance Reporting Information System	Reporting is mandatory but its use is optional per the Qualifying Individual Program, Supplemental Funding Act of 2008 (P.L. 110-379)	Cost avoidance
Lock-in programs	Optional	Cost avoidance
Prior authorization	Optional	Cost recovery and cost avoidance
Third-party liability and estate recovery	Mandatory per the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	Cost recovery and cost avoidance

Notes: ROI is return on investment. CMS is mandated to implement the Unified Program Integrity Contractors program per the Deficit Reduction Act of 2005 (P.L. 109-171).

Source: MACPAC, 2018, analysis of federal and state program integrity approaches.

Findings

The Commission's goal in collecting information from states on how they measure performance and ROI for certain PI approaches was to identify high-value activities across the Medicaid program. We predicted that a comparison of state procedures used and ROI obtained for these PI approaches would help states and the federal government make better decisions about how to efficiently allocate limited resources, particularly between PI activities that target cost recovery after payments have been made and PI activities devoted to cost avoidance by preventing payments that would otherwise have to be recovered.

As noted above, our findings were inconclusive. We discuss our specific findings below.

Challenges states face in measuring program integrity activities

There are several practical and structural reasons why it is challenging to gather usable ROI information on the full range of PI activities underway in states.

Lack of information on the expense of and return from PI activities. ROI is most easily calculated when there are clearly identifiable resources used to conduct the activity and when the results include countable recoveries by the state. Thus, discrete activities focusing on recoveries (e.g., data mining resulting in provider audits, RACs, and TPL and estate recovery) are most likely to be measurable with an ROI metric.

It is worth noting that two of these three approaches are federally required and have special reporting requirements that may facilitate ROI calculations. RACs are paid on a contingency

basis, so the return (the amount recovered) and the investment (fee paid to the RAC) are known and can be used to calculate ROI. TPL and estate recovery are specialized activities that are typically conducted by dedicated state staff or contractors, and staff and contractor costs can generally be identified and quantified. The costs avoided and recovered from these activities must be measured and reported separately on the CMS-64, thus making it easier to calculate ROI.

Other activities, including EVV and UPICs, might also generate results that can be used to calculate ROI because both are operated with dedicated resources and are intended to result in monetary recoveries. However, at the time this study was conducted, most states had insufficient experience with these approaches to be able to provide quantitative results. Moreover, given that these activities are mandated, states have little incentive to track the investments required for or returns obtained from these programs.

States reported that the structure of their operations was a complicating factor in tracking and reporting the costs and returns from various PI activities. In some states, PI operations are divided between the Medicaid agency and a state inspector general. Within a state Medicaid agency, some of the approaches included in this study, such as provider screening and enrollment, PARIS, TPL, and beneficiary lock-in programs, are managed by operational areas outside of PI. This division of responsibility complicates efforts by PI staff to identify and assign cost recoveries and cost avoidance needed to calculate the ROI of specific PI approaches.

Lack of consistent methodology for calculating return from PI activities resulting in cost avoidance. The return on PI investments can include both cost recovery and cost avoidance. While cost recoveries can be measured in dollar amounts, states use different methods to measure cost avoidance; these differences make it difficult to make direct comparisons across states.

Cost avoidance is an important component of many PI approaches, such as TPL and EVV. It is also the primary result of provider screening and enrollment, PARIS, beneficiary lock-in programs, and prior authorization. For some approaches, the methodology for calculating cost avoidance is straightforward. For example, TPL cost avoidance (which must be reported to CMS) is typically built into the claims adjudication system or MMIS. States use TPL edits to apply eligibility information and deny claims when a primary responsible party is identified (full cost avoidance), or calculate the allowable Medicaid paid amount when Medicaid is the secondary payer (partial cost avoidance).

For other PI approaches, there is little guidance from CMS or information that can be gleaned from Medicaid programs in other states. Moreover, states do not have consistent parameters for the cost avoidance calculation. For example, cost avoidance for beneficiary lock-in programs can be calculated by monitoring a period of avoided unnecessary physician, hospital, and pharmacy claims, but not all states use the same time period when accounting for savings. When measuring the return from provider screening and enrollment, some states consider claims avoided from a terminated provider as an ROI, while other states do not include avoided claims in their ROI calculations under the assumption that beneficiaries would have accessed those services from a legitimate provider and the state will incur the same cost. The differences among state methodologies for calculating return on cost avoidance strategies impede direct comparisons of ROI for these approaches.

Application of different performance metrics limits cross-state comparison. States measure PI outcomes to meet federal reporting requirements and to assess their own performance. In many cases, when given the option to develop their own metrics, states use measures that inform state priorities but do not support cross-state comparison or ROI calculation.

From a state management perspective, the overall effectiveness of PI activities may be the most important thing to measure. Activities do not exist

independently; for example, a single claim can be subject to both prior authorization and TPL review; a provider investigation can lead to an overpayment recovery and a termination. These situations make it difficult for a state to attribute costs or allocate recoveries to particular interventions. States may choose to report more easily quantifiable metrics, such as the number of cases that are referred to law enforcement for prosecution, as opposed to tracking which PI intervention was the source of the referral.

In addition, certain PI activities, such as provider screening and enrollment, EVV, TPL, and RACs are all federally required regardless of the investment required or ROI. Therefore, a state may not want to invest resources in tracking the results or calculating the ROI because it will not change the state's decision about continuing that activity. The state may instead track other measures of performance, such as the number of providers excluded from participation in a given year.

Non-quantifiable benefits of PI approaches. PI is important not only for detecting and reducing fraud but also for addressing abuse and neglect of beneficiaries. Prepayment approaches that keep bad actors out of the system, such as enhanced provider screening and enrollment procedures, prevent improper payments and protect patients from receiving substandard care. EVV can help ensure that personal care and home care providers are physically present to deliver services when the site of care is a patient's home; prior authorization processes help ensure that beneficiaries receive services that are medically necessary; and lock-in programs can prevent beneficiaries from receiving excessive quantities of prescribed drugs or other services. Although the costs avoided from these activities can be difficult to quantify for the methodological reasons outlined above, the improvements in patient safety and beneficiary health outcomes are of value.

States also incorporate PI findings into ongoing program improvement. For example, postpayment reviews may identify loopholes or inconsistent policies that providers can manipulate in the claims system. States can use findings to identify trends and make policy changes, deliver additional provider education, or recommend system edits to prevent future improper payments. States can also use findings to enhance existing automated fraud detection algorithms, provider screening tools, and other strategies.

States have expressed concern that a preference for cost recovery (which is easier to measure than cost avoidance) has led to overinvestment in postpayment approaches and less focus on prepayment and program management approaches. In addition, when recoveries can be quantified, these activities can be scored by the Congressional Budget Office (CBO) as budget savings, making them appear more beneficial than other activities when Congress makes policy decisions.

Opportunities to improve state PI strategies

In our March 2012 report to Congress, MACPAC noted concerns about whether PI efforts were making efficient use of public resources and recommended that the Secretary of the U.S. Department of Health and Human Services (the Secretary) take steps to determine which federal PI activities are most effective and eliminate redundant and outdated programs. In addition, the Commission called on the Secretary to develop methods for better quantifying the effectiveness of different PI strategies (MACPAC 2012). More recently, in its June 2017 report to Congress, MACPAC reiterated these recommendations in a chapter focused on PI in managed care (MACPAC 2017). CMS has yet to act on the Commission's 2012 recommendation.

These recommendations remain relevant and are consistent with the U.S. Government Accountability Office (GAO) framework for managing fraud risk in federal programs, which encourages program managers to consider the benefits and costs of activities and make investments in PI activities that offer the most cost-effective investment of resources (GAO 2015). In addition, the Office of

Inspector General of the U.S. Department of Health and Human Services (OIG) placed ensuring PI and effective administration as number 3 on its list of the top 12 management and performance challenges facing the department in 2018 (OIG 2018).

CMS has neither taken a leading role in filling the information gaps identified by our research, nor an active role in identifying the design and implementation features that result in effective programs. The RAC program is an example of a federally mandated activity that would benefit from further examination by CMS to identify the features of policy design and implementation associated with success.

Federal responsibility to protect the integrity of the Medicaid program. As noted in prior MACPAC reports, the federal role in Medicaid PI is constrained by the fact that eligibility and payment processing occur at the state level. As such, federal strategies contain few details or focus on assisting or auditing single states. CMS itself has noted the challenges in providing detailed guidance to states given the differences among state coverage, pricing policies, and payment systems.

Conducting a rigorous assessment of PI efforts across multiple states would be more useful in helping identify which optional PI strategies have high value, and in providing guidance in designing and implementing both optional and mandatory activities for maximum effect. In addition, the federal government is best positioned to test new models and improvements to existing programs and to share this information in a way that helps states invest in policies and strategies that work and eliminate potentially ineffective, redundant, and outdated programs.

CMS, however, is not focused on making specific improvements to methods for calculating ROI in state Medicaid PI programs, instead concentrating its efforts on Medicare. For example, in its 2016 annual report to Congress on Medicare and Medicaid integrity programs, CMS highlighted its methodology for evaluating the ROI in Medicare PI but did not offer an ROI methodology for Medicaid (CMS 2016). CMS officials we interviewed indicated that the agency works directly with states to help them develop their own ROI methodologies but provided few details.

In June 2018, CMS announced "new and enhanced initiatives that will create greater transparency in and accountability for Medicaid program integrity performance, enable increased data sharing and robust analytic tools, and seek to reduce Medicaid improper payments across states" (CMS 2018). These activities focus on audits of states, reviews of eligibility determinations, and the availability of improved data. The announcement did not mention how CMS and states will measure the performance, such as the ROI, of these new and enhanced initiatives; rather, it cites plans to continue to focus on the overall Medicaid improper payment error rates (CMS 2018).

The agency provides states with technical assistance on Medicaid PI activities but has not focused on measuring the effectiveness of these activities or broadly sharing information about them. CMS officials noted that they have not developed a methodology or guidance for calculating ROI in Medicaid, citing the complexity and variation across state Medicaid programs and payment systems. In addition, interviews conducted with state officials as part of our study found that most states rely on informal channels for learning about other states' practices. For example, the Washington State Health Care Authority reported over $70 million in cost avoidance attributed to its PARIS-Veterans Benefit Enhancement program, which identifies Medicaid beneficiaries receiving long-term services and supports who are eligible for but not enrolled in veterans' benefits, but other states we spoke with either did not know about the Washington results or had only learned about it directly from that state.

CMS collects information from states on PI activities (e.g., focused state PI reviews, reports on collections from overpayments, payment suspensions due to credible allegations of fraud) and could use the data to compare PI strategies,

especially those that demonstrate substantial ROI, such as the PARIS-Veterans Benefit Enhancement Program in Washington and the Long Term Care-Asset Discovery Investigation program in Illinois as well as states with sustainable RAC programs. States would be in a better position to make informed PI program investments if CMS disseminated this information to all states.

Many state RAC programs are not sustainable. Our study also provided evidence that the RAC program is not effective in all states. It was initially assumed that if the RAC approach worked for Medicare and a small number of state Medicaid programs, then it would work for all states, but this has not borne out.

The RAC approach grew out of efforts by a small number of states to increase returns from postpayment reviews at little cost. By contracting with auditors on a contingency basis, states were able to offer contractor incentives for finding and recovering overpayments with minimal input needed from the state for data and policy support.

For a number of reasons, however, an increasing number of states now struggle to comply with the statutory requirement to operate a RAC program because contractors are having difficulty sustaining profitability. In some cases, states have made policy decisions in line with overarching PI or administrative goals (e.g., choosing not to pursue collection of certain overpayments, prohibiting the use of extrapolation), and these decisions make a RAC contract unsustainable. In other cases, program limitations (e.g., three-year look-back periods, low volume of FFS claims) reduce potential returns. RAC contracts are contingency-based and require an up-front investment, so contractors may be hesitant to take on the risk of bidding for a contract in a state where conditions are not favorable to earning contingency fees.

A review of CMS-64 data for eight states shows declining RAC recoveries, from $3.90 million in 2013 to $0.58 million in 2017. This is mainly because RACs focus on FFS claims and there is an insufficient volume of FFS claims for them to review in many states. States have the option to allow their RAC vendor to review managed care encounters, but CMS does not require states to do so. State Medicaid programs that predominately enroll beneficiaries in managed care, and consequently have a low number of FFS claims, must still seek a waiver. Because they work on a contingency basis, no vendor will bid unless the potential recoveries are anticipated to at least cover costs. This has resulted in contractors declining to respond to new bid requests or turning down offers to renew Medicaid RAC contracts in several states.

For all of these reasons, several states have been unable to procure a RAC to comply with the federal mandate, or they have requested a waiver of certain aspects of the requirement. Under current law, states unable to procure a RAC must seek CMS's permission to waive the statutory requirements. The time-limited waivers are granted for a two-year period, at which time states are required to resubmit their waiver request with an updated justification. In the past few years, 25 states have sought waivers from the RAC program: currently, 8 states have waivers due to procurement issues, 16 states have waivers due to low volume of FFS claims, and 1 state we interviewed was denied a waiver.

Commission Recommendations

Recommendation 3.1

The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.

Rationale

The federal government should take a lead role in developing and disseminating information on the effectiveness of Medicaid PI approaches. Specifically, as part of its statutory authority to protect the integrity of the Medicaid program, CMS should examine current state activities and establish pilot projects for new approaches to identify the policy design and implementation features that best help states reduce fraud, waste, and abuse, and provide specific information to states on PI activities that have high rates of return on investment.

The federal government currently works with all state Medicaid PI programs on a one-on-one basis. Such activity may be worthwhile, but it does not necessarily benefit other states. Conducting a rigorous assessment of PI efforts across multiple states would be useful for helping states identify which optional PI strategies have high value and for helping them design and implement both optional and mandatory activities to achieve maximum effect. In addition, the federal government is best positioned to test new models and improvements to existing programs and to share this information in a way that helps states invest in policies and strategies that work and identify potentially ineffective, redundant, and outdated programs to eliminate.

Implications

Federal spending. The Secretary would have to devote existing resources to collect information from states, determine which features of policy design and implementation contribute to the effectiveness of certain PI approaches, and disseminate the results to states. To improve the effectiveness of Medicaid PI strategies, the Secretary may also consider involving other U.S. Department of Health and Services divisions, such as the OIG or the Assistant Secretary for Planning and Evaluation.

States. This change is intended to provide states with additional information on the effectiveness of various PI efforts, which presumably would help them invest in strategies with better outcomes. Some level of state effort would be needed to supply the Secretary with data, assess current strategies, and test new ones. The level and nature of that effort would depend upon how pilot programs and program assessments are conducted by the Secretary.

Enrollees. Although there would be no direct effects on beneficiaries, presumably beneficiaries would see improvements in care from states that are effective in preventing fraud, waste, and abuse, and when payments are properly made for high-quality provider services. PI strategies could improve outcomes for beneficiaries and avoid any burden on providers that may ultimately limit access or impede benefits for enrollees.

Plans. The effect on MCOs will depend upon the strategies the Secretary studies and promotes in relation to the current practices of those MCOs; for instance, whether the MCOs will have to modify their operating procedures or conduct more reporting activities, such as providing reliable and timely encounter data.

Providers. The identification of effective features for policy design and implementation could lead to a reduction of the administrative burden on providers and ensure the state's PI activities are efficient and focused on making appropriate payments for covered services.

Recommendation 3.2

To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

Rationale

Under the RAC program, states must contract with auditors to conduct postpayment reviews of Medicaid claims to identify overpayments. These

vendors are charged with finding and recovering overpayments and they are paid on a contingency basis, receiving as compensation a portion of their collections. The program requires minimal investment from the state, but the state does need to comply with the requirement of engaging a RAC.

The RAC program was made mandatory for all state Medicaid programs in 2010. After some years of successful implementation, however, RAC recoveries declined by about 85 percent from 2013 to 2017, and states are now having difficulty finding RACs willing to partner with them, forcing these states to seek waivers.

For many states, the RAC program has become an administrative burden due to the time and resources it takes to solicit a RAC vendor, manage procurements (many of which have failed), and prepare waiver applications and renewals.

Given the challenge many states have in contracting with RACs and the necessity of obtaining waivers from the statutory requirement, it is the Commission's view that Congress should change the statute and make participation in the RAC program optional, as it was prior to the passage of the ACA. This is consistent with MACPAC's 2012 recommendation to ensure that PI efforts make efficient use of federal resources and do not place an undue burden on states or providers (MACPAC 2012).

We believe, however, that states that want to implement a RAC program should still have this option. The RAC program is an example of a mandated activity that would benefit from further examination by CMS to identify the features of policy design and implementation associated with success.

Implications

Federal spending. Under this recommendation, CMS would no longer need to review requests from states for waivers of the RAC requirement. CBO estimates that making the RAC program an optional state activity would increase federal spending by a modest amount: less than $50 million over one year and less than $1 billion over five years. It is important to note that CBO provides ranges rather than point estimates for MACPAC recommendations; this is the lowest cost range for a policy change that would affect federal spending.

States. This recommendation would give states the option of implementing a RAC program. States would no longer be required to procure a RAC vendor or pursue a waiver if they are unable or choose not to implement a RAC program. As a result, some states would be relieved of the administrative burden associated with failed procurements and the waiver application process.

Enrollees. Although there would be no direct effects on beneficiaries, the reduced state administrative burden could potentially free up resources that could be directed to Medicaid beneficiaries.

Plans. We do not anticipate this change would have a measurable effect on Medicaid MCOs.

Providers. Removing the mandate may result in the elimination of the RAC program in some states. This may, in turn, reduce the burden on some states' providers due to fewer claims requests and audits. There would be no change for providers in states that continue to operate a RAC program.

Endnotes

[1] UPICs were formerly known as Zone Program Integrity Contractors, program safeguard contractors, Medicare-Medicaid data match contractors, and Medicaid Integrity Contractors.

[2] In 1993, the Omnibus Budget Reconciliation Act (P.L. 103-66) required state Medicaid agencies to recover some of the costs for providing care to a beneficiary over the age of 55 from the beneficiary's estate, either once admitted to a facility or after death.

[3] The estate of a Medicaid beneficiary is used to pay for services rendered until death. Undue hardship and other policies are in place to protect a surviving spouse or any surviving child who is blind or has a disability and who requires use of the assets.

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC § 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on improving the effectiveness of Medicaid program integrity. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 3.1 and Recommendation 3.2 on April 11, 2019.

Improving the Effectiveness of Medicaid Program Integrity

3.1 The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.

Yes:	Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno	16	Yes
		1	Not present
Not present:	Cerise		

3.2 To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

Yes:	Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weil, Weno	15	Yes
		1	Abstain
		1	Not present
Abstain:	Thompson		
Not present:	Cerise		