Utah Coalition of Medicaid Plans

ACO Comprehensive Program Integrity

The Office of the Legislative Auditor General (OLAG) reported in February 2018, that the legislative auditors spoke to CMS staff who suggested an ACO overpayment* recovery rate of 1-10% of medical costs. OLAG concluded that Utah ACOs did not meet this stated target because the CMS report included only recoveries from fraud and abuse investigations, which is only a small percentage of total overpayment recoveries.

The ACOs' overpayment recoveries currently meet the CMS 1-10% recommendation.

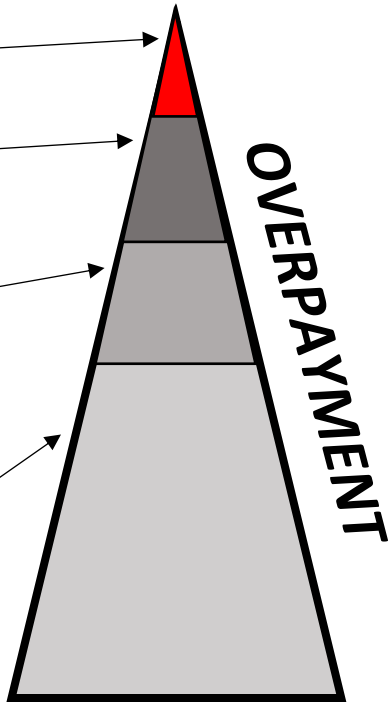
- Overpayment recoveries include fraud, abuse, waste, and billing errors (see graphic below). The OLAG report cited the CMS staffer's 1-10% recommendation for all overpayments but only included the ACOs' fraud recoveries in its calculation to determine the sufficiency of the ACOs' overpayment recoveries.
- A 2017 federal CMS audit of Utah's Medicaid Program Integrity, that OLAG cites, refers only to the ACOs' fraud-related recoveries. The CMS report acknowledges that other elements of the ACOs' Program Integrity activities should be included to have an accurate view of overpayment recoveries.[1]
- The graphic below represents the elements of all Program Integrity activities, as defined by CMS, recommendations from CMS, and the ACOs' current actions.
- These overpayment recoveries are already accounted for in the rates paid to the ACOs by the State. Each ACO reports claims-level data, called encounter data, to the State. The encounter data is used to set each ACOs' rate. As an ACO collects an overpayment, it is reported to the Utah Department of Health.

FRAUD/INTENTIONAL DECEPTION: Result in referral to Office of the Inspector General. This segment of recoveries is discussed in the CMS audit and OLAG report.

ABUSE/"BENDING THE RULES": Result in Administrative Actions such as revoking Provider's billing privileges.
- ACOs may terminate Provider contract.

WASTE/INEFFICIENCIES: Result in Selective Repayment Review of Claims.
- ACOs require Prior Authorizations, Referrals and/or back-end claims review, and benefits coordination with primary insurance.
- Detailed itemized bill reviews are conducted on high dollar claims prior to payment, to identify errors, incorrect billing, and unsubstantiated charges.

BILLING ERRORS/MISTAKES: Includes incorrect coding. Result in targeted Provider Education via the ACOs.
- ACOs actively work with the provider community to establish a feedback loop for continuous improvement. Program integrity strategies are implemented in partnership with contracted providers.



CMS estimates **85%** of program integrity savings are from Prevention/Cost Avoidance Strategies[4] (below) and **15%** are from Overpayment strategies (above).

ACOs PREVENT OVERPAYMENTS/AVOID COSTS BY
- Utilizing pre-payment audits
- Credentialing and contracting providers
- Identifying primary insurance and coordinating benefits
- Applying pre-payment edits and editing software

*An "overpayment means any payment made to a provider by a managed care plan to which the provider is not entitled."[2] Overpayment includes fraud, waste or abuse. Overpayment also includes billing mistakes and errors.
Fraud means an intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to that person.[3]
[1]HHS/CMS Center for Program Integrity. Utah Focused Program Integrity Review. June 2017.
[2]42 CFR 438.2
[3]42 CFR 455.2.
[4]CMS Annual Report to Congress on the Medicare and Medicaid Integrity Program. FFY2015.