STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

JAN 10 2012

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2011 Joint Chairmen's Report (p. 83) – Independent Report on Program Integrity Improvements

Dear Chairmen Kasemeyer and Conway:

Pursuant to the 2011 Joint Chairmen's Report (p. 83), the Department of Health and Mental Hygiene and the Department of Human Resources are submitting the enclosed report on Medicaid program integrity improvements.

Last year, DHMH and DHR submitted an independent report (compiled by The Lewin Group) as required by the 2010 Joint Chairmen's Report (p. 91) on the ability to maximize savings from minimizing claims processing and eligibility payment errors, and employing additional utilization review strategies beyond efforts already undertaken. DHMH and DHR reviewed the Lewin report and agreed with most of the recommendations. Language added to the fiscal 2012 budget requested that the agencies report on the progress in implementing the recommendations from that report. The attached document provides updated responses to the recommendations in the Lewin report.

Thank you for your consideration of this information. If you have questions about this topic or need further information, please contact Marie Grant, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene

Sincerely,

Theodore Dallas
Secretary
Department of Human Resources

Enclosure

cc: Chuck Milligan
Tricia Roddy
Audrey Parham-Stewart
Chuck Lehman
Marie Grant
Rosemary Malone
Vince Kilduff
Kelley Ray
Debbie Ruppert

2010 Independent Report on Medicaid Cost Savings and Dec. 2011 Updated Responses: Payment Errors, Eligibility Errors, and Utilization Review

Option	Lewin Recommendation	DHMH/DHR Response
MMIS Upgrade	Replace aging claims processing system with new one that is more flexible in implementing new programs, clinical edits and cost containment initiatives.	Agree. DHMH is currently completing the procurement process for replacing MMIS. The new system is expected to be implemented in September 2013. **Updated Response (12/2011)**: The revised schedule for implementation of the MMIS upgrade is now October 2014.
RAC Contractor	ACA requires states to have a RAC in place to identify payment errors and recover overpayments by December 31, 2010. The Department already contracts with a vendor that identifies payment errors and recovers overpayments. The ACA RAC requirement may impact the scope of the Department's Bill Audit contract.	Agree. DHMH contracts with bill auditors to review claims from hospitals, physicians, and nursing homes. DHMH is working with CMS to determine how the ACA RAC requirement will impact current contracts. The new federal requirements may expand the services reviewed under a RAC contract. Additional services may include home- and community-based waiver services. **Updated Response (12/2011)**: Although DHMH meets basic RAC requirements, it is developing a new RFP to expand the scope of work currently performed by the contractors.
Claims Queries	Run queries on a periodic schedule and the results to be tracked to indicate ongoing utility and ROI.	Agree with clarification. We are currently performing claim reviews on a regular basis. SURS is used for reviewing claims. Additionally, the MIG Audit Contractor and DHMH's Bill Auditor are using the same algorithms and NCCI edits to capture any potential claims processing or payment errors. **Updated Response (12/2011)**: OIG is continuing to conduct audits using SURS and our MIG auditors.
CARES Improvement	Eligibility Restructuring required in health reform may present an opportunity to upgrade the technology infrastructure upon which the eligibility system is currently built, and a recent proposed federal regulation would provide 90 percent federal match for eligibility system enhancements.	Agree. DHMH and DHR have developed an IT workgroup for the purpose of analyzing our current and future technology needs. Both agencies are committed to working together to ensure that we maximize funding opportunities. DHMH already applied to receive an Innovator Grant on December 22, 2010. If awarded, grant monies will be used to develop a new front-end eligibility system. DHMH and DHR already are discussing options for using the 90 percent federal funding to replace the back-end CARES system. This enhanced funding is only available to states until December 31, 2015.

Option	Lewin Recommendation	DHMH/DHR Response
CARES Improvement (cont'd)		**Updated Response (12/2011)**: In 2010 and 2011, DHMH was awarded three federal grants from CMS for planning, early innovation, and establishment of an exchange. On October 21, the Maryland Health Benefit Exchange released an RFP to procure a modern, consumer-friendy eligibility and enrollment system to support Maryland's implementation of key elements of the Affordable Care Act. The proposal submission period closed on Dec. 5, 2011.
Training Enhancements	Enhanced equipment and software could provide online Webinar training, policy learning modules, and periodic quizzes. These technologies could expedite training thus reducing possible eligibility determination errors.	Agree. DHR and DHMH will determine the cost associated with achieving this recommendation. **Updated Response (12/2011)**: Staff at DHR and DHMH have participated in the development of an online training tool to supplement and reinforce policy and procedural elements to minimize eligibility payment errors.
DHR Staffing & Backlog	To reduce eligibility errors, DHR would need to add more caseworkers, supervisors, programmers and other staff to address two fundamental problems – chronic understaffing among eligibility workers and a backlog of unfulfilled CARES programming requests.	Agree. DHR has contracted with the University of Baltimore to conduct a Workload Standards Study in order to determine the staffing complement that is needed in the local departments of social services. DHR is committed to developing technology improvements based on the 90 percent federal funding opportunity that is available to states until December 31, 2015. These technology improvements present an opportunity to redeploy staff in other understaffed areas, such as long-term care eligibility. In the meantime, DHR can calculate a time and cost estimate for specific programming requests. **Updated Response (12/2011)**: DHR is addressing concerns about staffing on three tracks. First, the Department is taking several steps to modernize its technology infrastructure. IT initiatives include implementing document imaging (now in pilot phase) and modernizing CARES with new business process management services components. Second, as part of DHR's response to the Thompson case, DHR has implemented six best practices in all local offices (including group redeterminations) that will improve the allocation of limited staff resources. Finally, DHR is supplementing these efforts with overtime for case management and line supervisory personnel in local offices. These steps will function as a bridge to the implementation of the Affordable Care Act/Health Exchange System, which will include

Option	Lewin Recommendation	DHMH/DHR Response
DHR Staffing & Backlog (cont'd)		additional improvements in the eligibility determination process.
DHMH Staffing and Potential Cost Savings	DHMH might achieve some cost savings by hiring additional staff to perform outreach to beneficiaries who may enroll in Medicare.	Agree. DHMH is currently working on this project as a 2011 cost containment initiative. Medicaid federal rules require potential Medicare-eligible individuals to apply for Medicare benefits. DHMH currently is assisting ESRD recipients with their application for Medicare benefits. **Updated Response (12/2011)**: Outreach to beneficiaries age 65 and older remains a top cost-containment initiative for FY12 at DHMH. In July 2011, DHMH sent approximately 500 notices to MA recipients with End Stage Renal Disease advising them to apply for Medicare benefits for which they may be eligible for. To date 118 cases have been approved for Medicare; 117 are ineligible and 87 are still pending.
Review Payments Identified in Targeted Analysis	DHMH may be able to prevent or detect future instances through new edits or reporting processes (e.g., flagging for review all Medicare crossover claims for individuals not identified in MMIS as Medicare enrolled)	Agree, however, this procedure is currently in process. Over the last 17 months, DHMH has recovered $11 million from its "reverse-crossover" initiative. The "Reverse-Crossover" initiative compares new Medicare buy-in data and creates transactions when retroactive eligibility is found. The MMIS claims system processes these transactions to see if any Medicaid claims were paid for recipients who are found to be Medicare eligible on the date of service. If so, the money is retracted from the original provider informing him/her to bill Medicare. In addition, DHMH contracts with a third party vendor to conduct post-payment recovery efforts. **Updated Response (12/2011)**: Over the last two years, DHMH recovered $18.5 million for the "reverse-crossover" initiative.
Develop Automated Process to Replace Manual Transactions	Lewin's report references & supports the time studies completed by DHMH to automate manual process.	Agree. DHMH completes roughly 9,000 monthly manual corrections due to discrepancies between MMIS and CARES. Over the last three months, DHMH has reduced these monthly manual corrections by 10 percent by automating processes. DHMH will continue to automate processes in order to reduce work hours and errors associated with manual eligibility processes.

Option	Lewin Recommendation	DHMH/DHR Response
Develop Automated Process to Replace Manual Transactions (cont'd)		**Updated response (12/2011)**: The interface to transmit SSNs between CARES and MMIS was completed in late October. The Department will continue to work on identifying additional opportunities for streamlining productivity.
Review PARIS Matches and Calculate Enrollment Savings	Further review of PARIS data may reduce eligibility payment errors by identifying beneficiaries with access to federal health benefits.	Agree. DHMH is currently reviewing other states' best practices for improving its use of PARIS matches. DHMH will develop a work plan outlining any identified improvement opportunities. **Updated Response (12/2011)**: DHMH is currently developing a Monitoring and Special Projects Unit that will perform targeted reviews and make recommendations.
High-Cost Case Review Team	DHMH should establish a clinical review team to monitor and investigate high-cost users of Medicaid services.	Agree. DHMH will determine the cost and savings associated with achieving this recommendation. **Updated Response (12/2011)**: DHMH developed two high cost teams. One team meets to discuss high-cost users with complex health needs, who are served by multiple programs. The purpose is to streamline processes and make sure individuals receive the most cost-effective services. The second team examines new high cost technology and drugs to determine if the services should be preauthorized or monitored.
PI-MCPA Collaboration	Greater transparency on the program integrity and surveillance activities, including broad-based SURS runs that have been completed by PI staff. This recommendation is aimed at improving collaboration between the OIG and MCPA.	Agree with clarification. The OIG and MCPA will work closely to identify successful algorithms where appropriate. **Updated Response (12/2011)**: The OIG and MCPA staff meets regularly to review pending investigations. The OIG will provide training to MCPA regarding SURS runs to facilitate MCPA performing its own runs. The OIG performs "routine" runs, as well as ad hoc reports, and will review the routine reports on an 'as needed' basis with MCPA to ensure the necessary information is being sought.
UR Strategic Plan	The Department should develop an annual strategic plan for UR activities. It should be jointly developed with MCPA program staff, DDA and MHA.	Agree with clarification. The OIG and other Program areas will work collaboratively to develop a PI/UR strategic plan to the extent possible given the OIG's requirement of independence. The plan will be completed by March 2011 and will identify UR activities for FY12.

Option	Lewin Recommendation	DHMH/DHR Response
UR Strategic Plan (cont'd)		**Updated Response (12/2011)**: The OIG and other program areas will continue to collaborate on Program Integrity/Utilization Review issues. Due to staffing issues and the need to address ad hoc or immediate issues, development of an extensive or long-term plan is not practical at this time. Given recent issues regarding behavioral health, however, the OIG developed a plan to conduct more reviews in this area, if additional positions are received in the next fiscal year.
Hiring More Staff	Implementation of a full-scale program integrity strategic plan may require additional staff to develop audit leads, improve communication and interface between PI and Medicaid staff and recover overpayments from providers. DHMH would also benefit from additional clinical staff, beyond the current 4.5 nurses and 1 pharmacist qualified to assess medical necessity and clinical effectiveness.	Agree. DHMH anticipates additional reviews as a result of the False Claims Act. Specifically, the False Claims Act requires reviews to be completed within 60 days. These reviews require clinical assessments, which will result in more recoveries. DHMH will analyze and determine the staffing costs associated with these additional reviews. **Updated Response (12/2011)**: At present, the OIG is able to staff and review False Claims submissions; however, additional staff may be required, as the False Claims Act becomes more active.
HealthChoice UR Performance Measures	Reframe some of the performance measures toward reduction of undesirable high-cost service allocation and focus performance improvement plans (PIP) on reducing utilization of avoidable high-cost services.	Agree. We are willing to look at adding some performance measures that focus on UR to the current measures. Our experience with our home-grown measures has been that they are challenged more by MCOs and providers. Additionally, we are not convinced that there are more savings to be obtained since the MCOs are already focused on and proficient in controlling the utilization of high cost services. For future PIPs, we will explore topics that can combine UR with care improvement. **Updated Response (12/2011)**: We will continue to explore whether it is practical to combine UR with care improvement.
Electronic Verification for In-Home Services	Implementing electronic verification systems to track when providers are actually present in a Medicaid recipient's home.	Agree. This initiative will help ensure enrollees are receiving services by in-home providers. DHMH will identify the costs associated with implementing this initiative. **Updated Response (12/2011)**: DHMH is working on procuring a vendor to implement this project. We expect that it will be implemented by January 1, 2013.

Option	Lewin Recommendation	DHMH/DHR Response
Increased Use of Corrective Managed Care Lock-In Program	Review opportunities to lock-in MCO patients to one pre-determined pharmacy provider.	Agree. The Department will make the appropriate regulation changes and determine the cost associated with achieving this recommendation. Additional staff will be needed to increase use of the lock-in program. **Updated Response (12/2011)**: DHMH established regulations to allow MCOs to implement pharmacy lock-in programs.
Self-Auditing	Several states (e.g., Texas, Missouri and North Carolina) have initiated self-audit programs that allow providers to voluntarily identify and return overpayments without penalty. It was noted in the DHMH OIG 2008 Annual Report that this strategy was implemented effectively for out-of-state hospitals, resulting in over $600,000 in recoveries in FY08. DHMH has recently initiated this strategy for certain in-state providers. We suggest the State continue to look for additional self-audit opportunities.	Agree. The OIG has recently begun a self-audit program involving Evaluation & Management coding and will continue to use self-auditing whenever possible. **Updated Response (12/2011)**: The OIG developed a Medical Assistance Provider Self-Audit Protocol. Certain providers were asked to complete the audits. While this work does not necessitate additional staff, there are other workload issues that exceed current staff capacity and have limited OIG follow-up. Although the OIG recovered minimal funds, it will continue the project.