State of Maryland
Department of Human Resources

Maryland's Human Services Agency

Martin O'Malley
Governor

Anthony Brown
Lt. Governor

Brian Wilbon
Interim Secretary

December 27, 2010

The Honorable Edward J. Kasemeyer
Acting 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: 2010 Joint Chairmen's Report (p. 91) – Independent Report on Savings from Minimizing Claims Processing and Eligibility Payment Errors and Employing Utilization Review Strategies

Dear Chairmen Kasemeyer and Conway:

Pursuant to the 2010 Joint Chairmen's Report (p. 91), the Department of Health and Mental Hygiene and the Department of Human Resources are submitting the enclosed independent report on the ability to maximize savings from minimizing claims processing and eligibility payment errors, and employing additional utilization review strategies beyond efforts already undertaken. The report was due December 1, 2010, but the Departments were granted an extension for submission of the report to January 1, 2011.

DHMH contracted with The Lewin Group to provide an assessment of the administration's current strategies to minimize claims processing and eligibility payment errors in Medicaid and expand utilization review strategies and procedures. The Lewin group conducted interviews and requested data to perform their analysis. DHMH and DHR reviewed the Lewin report and agree with most of the conclusions and implications. It should be noted that many of the potential claims errors identified by Lewin were analyzed by the Department and found to have been paid appropriately.

The future of Medicaid's success rests on its ability to prepare adequately for the growth currently being experienced and projected changes in the future due to the impact of federal legislation. DHMH/DHR will need to allocate greater resources at all levels of the organization to reduce errors and manage service utilization.

The Departments prepared the following responses to the Lewin recommendations. Many of the recommendations require additional staffing and other resources and the Departments will determine the costs associated with achieving those recommendations.

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

Sincerely,

John M. Colmers
Secretary

Brian Wilbon
Interim Secretary

Enclosure

cc: John Folkemer
Audrey Parham-Stewart
Tricia Roddy
Chuck Lehman
Wynee Hawk

The LEWIN GROUP®

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—**WITH REAL-WORLD PERSPECTIVE.**

Independent Report on Medicaid Cost Savings: Payment Errors, Eligibility Errors, and Utilization Review

Prepared for: Maryland Department of Health and Mental Hygiene

Submitted by: The Lewin Group

Date: December 15, 2010

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Executive Summary

The Maryland Medicaid program currently spends more than $6.2 billion annually to provide health care for many of the State's neediest residents.[1] State budgets nationwide are stretched to their limits, and state legislatures are intent on ensuring that expenditures are being made efficiently. With the recently enacted Patient Protection and Affordable Care Act (ACA), national Medicaid spending is expected to increase even more significantly in 2014, requiring even greater emphasis on ensuring the program's integrity. As part of its fiscal year 2011 budget, the Maryland General Assembly required that the Department of Health and Mental Hygiene (DHMH) contract for an independent assessment of the activities that the Department takes to prevent errors in payment and eligibility, to review utilization of services, and provide recommendations to improve these activities. This report is divided into three sections, which focus on claims payment, eligibility, and utilization review.

Claims Processing and Payment Errors

DHMH conducts a variety of activities to identify and prevent claims processing errors and to ensure the functionality and effectiveness of "edits" in the Medicaid Management Information System (MMIS). Many of these activities are made more difficult because of the MMIS's outdated and limited functionality. The federal Payment Error Rate Measurement (PERM) initiative found rates of payment errors for Maryland below the national average (1.1 percent for fee-for-service compared to the national averages of 8.9 percent in fiscal year 2007). To complement PERM, we worked with DHMH officials to identify particular areas where vulnerabilities could result in errors. Based on our preliminary analyses, it appeared that claims payment errors were very infrequent, but present. Possible claims payment errors were provided to DHMH for follow-up. Further analysis revealed that a substantial portion of these possible erroneous claims were paid appropriately and were, in fact, not errors.

The most urgent – and most complicated – priority for the prevention of claims payment errors is replacement of the MMIS, a process that has already been initiated at DHMH. The new system should incorporate modern editing capabilities, based on best practices and designed specifically to enforce Maryland's policies. In the meantime, low cost claims error prevention strategies with the potential for return on investment (ROI) include contracting with a Recovery Audit Contractor (as required by ACA) and periodic tests for potential errors similar to those that we performed.

Eligibility Payment Errors

We also reviewed potential causes of errors in Maryland's processes for determining eligibility for Medicaid. The Department of Human Resources (DHR) manages the Medicaid eligibility process. DHR employs a centralized eligibility processing system, CARES, for determination of social services benefits, including Medicaid, and CARES transfers eligibility information to MMIS for provider reimbursement. DHMH and DHR conduct several activities to prevent eligibility payment errors.

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[1] Data from State fiscal year 2010.

The federal PERM process, last completed for Maryland in 2007, determined an eligibility payment error rate of 7.7 percent, compared to a national average of 2.9 percent in federal fiscal year (FFY) 2007. Errors appear to be attributable to staffing challenges and technological limitations.

Replacement or upgrades to CARES would be complicated and expensive, although it may be necessary to comply with federal health reform requirements. A newly proposed federal regulation, however, would provide 90 percent federal match for eligibility system enhancements intended to help states reduce eligibility determination errors and prepare for national health reform.

Utilization Review

Utilization review (UR) activities are conducted across DHMH by Medicaid staff, outside contractors, and the DHMH Office of the Inspector General, which manages the federally-required Surveillance and Utilization Review Subsystem (SURS).

We conducted targeted exploratory analysis on several areas likely to benefit from increased utilization review including pharmacy and emergency department (ER) services. In each of these areas we identified beneficiaries who appear to be overusing services. We also identified a small number of cases that appear to warrant immediate recoveries and identified several opportunities for better planning and coordination of UR processes.

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Through this assessment process, we identified a wide range of activities that DHMH conducts to maintain the integrity of the Medicaid program. This is consistent with Medicaid programs nationwide, as error prevention strategies and utilization review activities, many of which are federally-required, are a critical aspect of administering a high-quality and efficient program. For claims processing and payment errors, federal error measurement processes suggest that Maryland outperforms the national average. Nonetheless, greater investments in error prevention, error detection, and utilization review would improve overall program integrity and could help modestly reduce Medicaid expenditures.

1. Introduction

Through its Medical Assistance program, Maryland's Department of Health and Mental Hygiene (DHMH) and Department of Human Resources (DHR) provide access to health care for over 720,000 Medicaid and almost 100,000 Children's Health Insurance Program (CHIP) enrollees each month who might not otherwise have access to care. Annual expenditures for Maryland Medicaid are over $6.2 billion—and growing—and CHIP expenditures are over $191 million per year.[2] Especially in a time of increased fiscal difficulties, it is critical to ensure that DHR and DHMH staff accurately determine eligibility and DHMH accurately processes payments and targets benefits to those who truly meet eligibility requirements.

DHR and DHMH are facing increasingly tight budgets, while at the same time managing increases in the number of individuals seeking enrollment in Maryland's Medicaid and CHIP programs (hereafter referred to as Maryland Medicaid). The Departments' overall program integrity efforts strive to ensure that Medicaid spends its valuable resources on the right beneficiary, for the right service, at the right time. Improper payments, fraudulent or not, decrease funds available for other purposes. If just one percent of annual payments are in excess due to error, the amount of taxpayer money wasted would be over $57 million.

In Maryland, program integrity is a complex endeavor, particularly because of the diffusion of program authority. DHMH's Deputy Secretary of Health Care Financing oversees Maryland Medicaid. However, most Medicaid eligibility is determined by DHR staff. Also, some Medicaid program services, such as services delivered by the public mental health system and services for some individuals enrolled in home and community-based waiver programs, are administered by separate State departments or DHMH administrations. The Mental Hygiene Administration (MHA), for example, conducts claims adjudication and provider reimbursement in a payment processing system outside of the primary Medicaid claims payment system. Diffusion of program authority, while understandable given the complexities of Medicaid program administration, leads to challenges for developing comprehensive program integrity strategies for claims processing systems and eligibility determinations.

Further challenging program integrity efforts in Maryland, the State's Medicaid Management Information System (MMIS) and CARES (Client Automated Resource and Eligibility System) are aging and lack many of the sophisticated pre- and post- eligibility determination and adjudication claims processing surveillance mechanisms that are built into newer, more flexible systems. While Maryland Medicaid is currently procuring a fiscal agent to develop a new MMIS for the State, full implementation remains several years in the future. Likewise, enhancements to CARES are expensive and must be balanced against competing priorities.

In an effort to address some of these challenges, the Maryland General Assembly mandated that DHMH contract for an independent report to describe current strategies to avoid improper payments and, in conjunction with DHR, identify potential strategies to do so more effectively. This mandate was passed as part of the enactment of the State's fiscal year (FY) 2011 budget. To

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[2] Throughout this document, unless noted otherwise, we report total funds. Medicaid costs are shared between states and the federal government.

fulfill this legislative requirement, DHMH selected The Lewin Group through a competitive procurement to produce the report.

2. Research Methods

The assessment phase began with a series of interviews with DHMH staff. During these meetings, we identified strategies that DHMH currently uses to prevent errors in claims payments and eligibility, and mechanisms by which DHMH conducts utilization review activities. Following initial interviews with DHMH staff we collected a variety of program documents including policies, guidance, contracts, RFPs, and other reports that we used to understand current practices and to clarify the scope of identified strategies.

We also evaluated areas with the potential for errors and/or abuse to target for claims analysis. Those areas included:

- Payments made on behalf of individuals who are not Medicaid eligible
- Fee-for-service payments made on behalf of individuals enrolled in managed care for service that are not carved out
- Services rendered by providers that were not enrolled with Medicaid
- High ER, physician, and pharmacy utilization by a small subset of beneficiaries
- Payments made on behalf of enrollees who are over age 65 and eligible for, but not receiving Medicare payments

To quantify the extent of errors in these target areas, we requested claims, eligibility and provider files for FY 2009 from the Hilltop Institute at the University of Maryland, Baltimore County and ran a series of analyses. These files were used to validate the accuracy of MMIS claim payments and investigate claims for potential overutilization. We matched paid claims with the eligibility file to validate that the beneficiary was eligible on the date of service. We also matched claim files with the provider enrollment file to verify that the provider was enrolled on the service date. Claims were also summarized by beneficiary ID to identify individuals with paid claims indicating potential overutilization of services. For claims identified as potential errors, Lewin provided the claims to DHMH staff for follow-up and further analysis. When DHMH's further analysis findings were available prior to delivering this final report, we incorporated information about those findings in this report.

To further investigate the extent of eligibility payment errors, we conducted a post-review of undetermined cases from the FFY 2007 PERM cycle. We requested complete PERM case files for all undetermined cases from DHMH. As PERM has recently promulgated new final regulations which have the potential to alter some future eligibility error determinations, we reviewed the Medicaid cases that DHMH staff provided to determine if case findings would have been altered had they been reviewed under the new final regulation. We then attempted to quantify the impact on the error rate. This analysis intended to identify and quantify possible future PERM eligibly error rate shifts based only on the modifications to the PERM regulation.

Limitations

Time and budget constraints precluded our ability to conduct a full scale claims and eligibility audit and a comprehensive identification of the prevalence of errors. Therefore, we worked

with DHMH staff to identify areas with the greatest potential for errors. Our analyses found a modest number of claims that were potentially paid erroneously. Lewin provided potential errors to DHMH for follow-up. DHMH analysis revealed that a majority of potentially erroneous claims were, in fact, paid appropriately.

3. Claims Processing and Payment Errors

The vast majority of Medicaid expenditures and payment transactions are attributable to either "claims," a process through which providers invoice DHMH for delivering Medicaid-covered services, or to "capitation payments" through which DHMH makes monthly per member per month (PMPM) payments to managed care organizations (MCOs) to provide a defined package of services to distinct individuals. While the volume of claims and payments is largely driven by claims in Medicaid's fee-for-service (FFS) programs where individual providers bill for discrete services, managed care PMPM capitation payments account for nearly a third of total Medicaid expenditures.

Generally, there are numerous causes for claims processing and payment errors, ranging from simple administrative billing errors to MMIS adjudication failures. For this report, we considered a "claims processing or payment error" to be a FFS reimbursement or capitation payment which DHMH paid to a provider or managed care entity but for which the claim, service, or resulting payment amount did not comply with State or federal payment rules.

We view "claims processing and payment errors" for this analysis as both "system processing errors" and "medical record errors" in both FFS and managed care. In this report we collectively refer to these as "claims processing and payment errors." [3] Examples of system processing errors include incorrect processing (e.g., duplicate of an earlier payment, payment for a non-covered service, payment for a beneficiary whose eligibility span has ended) and incorrect payment amounts distributed to providers (e.g., incorrect fee schedule or capitation rate applied, incorrect third party liability applied). Medical record errors are often only identifiable upon review of the beneficiary's medical record. Medical record payment errors include instances where the provider incorrectly coded a claim, billed improperly (e.g., unbundling, incorrect number of units), or lacked documentation of medical necessity for services provided.

States across the country employ a range of strategies to minimize both system processing errors and medical record errors. In the remainder of this section, we discuss the current strategies that DHMH employs to prevent or identify claims processing and payment errors. We also analyze the extent and causes of claims processing and payment errors and address potential strategies to minimize these errors in Maryland Medicaid.

Assessment of Current DHMH Strategies to Reduce Claims Processing and Payment Errors

DHMH implements a variety of strategies to reduce claims processing and payment errors. A discussion of these strategies follows. We have also included an inventory of strategies in Appendix A.

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[3] We defined system processing errors and medical record errors based on the PERM final rule: "Medicaid Program and Children's Health Insurance Program (CHIP); Revisions to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Program; Final Rule," 75 Federal Register 154 (11 Aug 2010), pp 44816-44852. Available Online <https://www.cms.gov/PERM/Downloads/Fin_Rule_Aug_1.pdf>

As discussed in more detail below, DHMH identifies claims processing errors primarily through strategies in the following categories:

- Developing and placing claims logic checks known as "edits" in MMIS
- Establishing utilization review criteria in MMIS
- Completing monthly managed care capitation reconciliations
- Provider documentation review

To a lesser degree, report monitoring, claims preprocessing, facilitating provider training, encouraging electronic billing, long-term care onsite record review, provider credentialing, service preauthorization, coordination of benefits, and home and community-based services (HCBS) waiver billing systems also reduce claims processing errors. In addition to implementing these strategies within the Department, DHMH also contracts with vendors for pharmacy, dental administrative services, and specialized mental health to perform a variety of claims review and payment functions.

MMIS Edits

In all state Medicaid programs, the MMIS is the primary vehicle for adjudicating claims for FFS reimbursements; and, for most states, including Maryland, the MMIS is also the primary system for processing capitation payments. The Centers for Medicare and Medicaid Services (CMS), which oversee all state Medicaid and CHIP programs at the federal level, require each state to develop an MMIS with the mechanized capacity to accept and pay standard claims for reimbursement and provide explanation of benefit statements to providers. CMS also requires MMIS functionality to facilitate the accuracy of claims processing by requiring the inclusion of a surveillance and utilization review subsystem (SURS) in the MMIS and requiring that states incorporate MMIS logic checks known as "edits" into the system. At a minimum, edits must run basic checks on all information entering the system to ensure for proper field content, data accuracy, and data reasonableness.[4] [5] However, traditionally, CMS has not dictated to states the actual edits required in the MMIS.[6] Maryland implemented and CMS certified Maryland's MMIS-II 1996. While DHMH is engaged in the procurement of a replacement MMIS, the system originally acquired from the State of Florida, remains in use as of the date of this report.

As with all states, DHMH's major strategy for reducing claims processing and payment errors is a reliance on system edits. The MMIS is programmed with edits for a variety of subsystems and processes. Edits may be hard-coded into system logic programming or may be reflected on

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[4] In recent years, CMS has moved away from using the term SURS, and instead, refers to the functions as a component of a program integrity business area.

[5] 42 CFR 433, subpart C; CMS State Medicaid Manual, Chapter 11.3: Medicaid Management Information System – System Requirements. Available Online: < http://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>

[6] The Patient Protection and Affordable Care Act, Section 6507, requires that each state Medicaid program implement compatible methodologies of the National Correct Coding Initiative, to promote correct coding and to control improper coding leading to inappropriate payment by October 1, 2010. State Medicaid Director letter, September 1, 2010, Re: National Correct Coding Initiative. Available Online: <http://www.cms.gov/smdl/downloads/SMD10017.pdf>

subsystem "screens" allowing for table-based updating by authorized users. Editing decisions throughout the adjudication process result in a claim's authorization for payment, denial of payment, or suspension for later manual review by DHMH staff. Edits may also result in the inclusion of an edit explanation on the claim's explanation of benefit statement. Examples of edits vary widely in their type and specificity. For example, one of the most common reasons for claim denial is an edit that denies payment if the State has previously paid the same claim. ***Exhibit 1*** includes examples of basic edits. DHMH's reliance on edits as the major strategy to reduce claims processing errors is similar to other states.

Exhibit 1: Examples of Basic MMIS Edits

Area of Edit	Edit Description
General	Determines if the State has previously paid the same claim
Beneficiary	Determines if the beneficiary was eligible for the service on the date(s) of service
Beneficiary	Determines if the beneficiary was eligible for the particular service billed (e.g., eligible for a long-term care service)
Beneficiary	Based on HealthChoice enrollment, determines if the provider should seek reimbursement from the MCO
Procedure	Determines if the procedure code on the claim is active
Procedure	Determines if the units of service on the claim are within set requirements
Provider	Determines if the provider claiming reimbursement is actively enrolled in the program
Provider	Based on the type of provider and procedure category of service, determines if the provider is eligible for reimbursement for the procedure code

Legislative Audit Report and Resulting Actions

MMIS edits have been a major area for review by Maryland's Office of Legislative Audits (OLA) in recent years. OLA most recently published a performance audit of DHMH's Medicaid claims processing and federal reimbursement procedures for the period between July 1, 2007 and March 31, 2008. One of the primary audit priorities was to determine whether it was appropriate for DHMH to disable or override 81 MMIS edits. Auditors concluded that nine of the 55 edits reviewed were inappropriately overridden, and should have been applied to over

$98 million in claims. Additionally, the auditors could not confirm the appropriate status for six of the edits with overrides for which claims totaled $186 million.[7]

In response to the OLA findings, DHMH staff reviewed MMIS edit overrides. While a full review of MMIS edits was outside the scope of this report, our interviews with State staff focused on the editing process and DHMH's efforts resulting from the findings of the most recent OLA report. We also reviewed internal reports and spreadsheets indicating the findings of DHMH's review.

Of the six edit overrides for which the auditors could not determine the appropriate status, DHMH staff review found that all edit overrides are appropriate. Four edits are appropriately disabled because the edits do not apply to payment processing for the claim type. DHMH determined that one edit override was appropriate because the logic was an artifact of the base MMIS programming and does not apply in Maryland.[8] The remaining edit override was appropriate because it allowed Medicare beneficiaries to receive specialty mental health services not covered by Medicare. Because DHMH staff found that all edit overrides were appropriate, the review resulted in no recoverable funds and DHMH will take no further action on these edits.

DHMH staff also reviewed the nine edits for which the auditors indicated that the edit overrides were inappropriate to determine if the Department concurred with the audit findings, identify the recoverable funds, and determine the appropriate course of action for the edit. We have summarized the Department's findings in ***Exhibit 2***. Overall, of the $98 million indicated by the auditors, the Department's review to date of the actual claims found only $85,074 as possibly recoverable by the State.[9] Investigation of the $85,074 of possible recoverable amounts remains in progress (i.e., this total may be further reduced) with a planned completion scheduled for December 31, 2010.

Edit overrides do not necessarily result in claims processing and payment errors. On the contrary, when properly deployed, edit overrides legitimately manage system payments, especially within aging MMIS architecture. Note that for many of the edit overrides that DHMH staff reviewed based on the OLA report, the override was specific only to a particular type of claim; for a vast majority of claims the edit remained fully operational. For example, several overrides were limited to claims from MHA.[10] The discrete ability to override edits only for particular types of claims affords DHMH staff a resource to accurately pay claims.

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7 Office of Legislative Audits: Department of Legislative Services, Maryland General Assembly. Performance Audit Report: Department of Health and Mental Hygiene Processing of Certain Medicaid Claims, Nov. 2009.

8 Maryland's MMIS II was based on the system then in use in Florida's Medicaid program.

9 MHA had reviewed and already recovered some additional dollars prior to audit review.

10 MHA fully adjudicates claims, including subjecting claims to an editing process in a separate claims payment system. MHA processes claims in MMIS for purposes of federal financial participation only.

Exhibit 2: Findings from DHMH Review of Edit Overrides Deemed Inappropriate by OLA

Edit Description	Totals Indicated by OLA	Possibly Recoverable Amount	Department Findings	Department Actions
Exact duplicate of previously paid claim	Claim count: 5,052 Dollars: $503,659	$0	Edit override for MHA Edit reinstated prior to audit publication; MHA previously reviewed claims and recovered payments where applicable	No further action required based on this review
Possible duplicate service by same provider	Claim count: 367 Dollars: $86,014	$0	All claims identified were processed and paid by MHA	MHA determined claims were paid appropriately; no payment recoveries; no further action required
Inpatient claim in conflict with outpatient claim	Claim count: 2,782 Dollars: $33,913,555	$0	Claims attributable both to MHA (1,716 claims) and other FFS payments (1,066)	MHA determined claims were paid appropriately; review determined other claims paid appropriately; no payment recoveries; Medicaid creating routine report for program's bill auditor to use in conducting targeted reviews
Procedure not allowed with other procedure	Claim count: 6,491 Dollars: $342,830	$0	Edit override for MHA and Medicare crossover payments Medicare crossover payments should not be subjected to this edit	MHA determined claims were paid appropriately; no payment recoveries; no further action required
Claim past filing limit	Claim count: 29,919 Dollars: $34,060,111	$0	Edit override for MHA and DDA claims MHA and DDA independently pay claims and submit to the MMIS for purposes of FFP	No review or further action required
Third party coverage	Claim count: 39,569 Dollars: $14,243,643	$2,300	Edit override for long-term care payments As few third parties pay for long-term care services, the Department decided to continue with a pay and chase approach	TPL vendor reviewed approximately 20,700 claims as indicated by OLA 52 resulted in third party payments totaling $2,300

Edit Description	Totals Indicated by OLA	Possibly Recoverable Amount	Department Findings	Department Actions
Procedure invalid for recipient in a long-term care facility	Claim count: 42,263 Dollars: $4,000,941	$82,774	Review indicated that many procedure codes were inappropriately marked as conflicting with edit (codes should not have "hit" this edit at all) Remaining codes in conflict with edit will continue to pay and be followed by post-payment SURS review	Coding modified on inappropriate procedure codes Procedure where edit should be in place codes reduced possible recoverable amount to $1.9 million; reviewing claims against actual long-term care billings and prior authorizations reduced possible amount to $82,774; continuing to conduct a manual review
First diagnosis not on file	Claim count: 1,750 Dollars: $8,724,369	$0	Review determined that these claims were appropriately paid because it is the utilization review agent, not the claim diagnosis, determining the appropriate level of care	Provider billing instructions modified to not require diagnosis code; no further review required
Inpatient claim and the source of admissions is not valid	Claim count: 627 Dollars: $2,719,835	$0	Review determined that these claims were appropriately paid because it is the utilization review agent, not the source of admission, determining the appropriate level of care	Provider billing instructions modified; no further review required
	$98,594,958	$85,074		

Other Screen Editing Reviews

In calendar year 2009, independent of the OLA report, DHMH staff conducted a full review and reprogramming of the MMIS processing logic, called "screen 19," that identifies payments as covered or not covered when a beneficiary is enrolled in a program with defined benefits. For example, when a beneficiary is enrolled in HealthChoice, screen 19 will not allow MMIS FFS reimbursement of services such as acute care hospital coverage and practitioner visits that are included in the managed care benefit package. Screen 19 edits would, however, permit payment in MMIS FFS for services not included in the managed care benefit package such as specialized mental health services and Home and Community Based Service (HCBS) waiver services. In addition, screen 19 edits allow DHMH to limit waiver services only to recipients specifically enrolled in HCBS waivers. DHMH staff indicated that the review and reorganization of screen 19 may have reduced claims processing and payment error by ensuring that DHMH reimbursed FFS only for services not covered under capitated benefit packages and ensuring that only individuals enrolled in HCBS waivers received HCBS waiver services.

Utilization Review Criteria

Within the MMIS, DHMH employs another type of editing using utilization review (UR) processing logic. UR criteria allows DHMH staff to establish criteria against which the MMIS will edit, often relying on information in the MMIS claims history files (i.e., the UR criteria causes a review of previous payments to determine if the system should permit payment or trigger a denial). Most established UR criteria fall into several groupings as displayed in ***Exhibit 3.***

Exhibit 3: Types of UR Criteria

Type of UR Criteria
Procedure lists indicating similar or related codes may be set, for example, such that when one code in the indicated group has paid any subsequent billings will deny
Contraindications list deny code X if code Y has already paid
Limit parameters allow users to designate limits on service units during a specified period of time. Units billed above the limit for the established code will deny

UR criteria logic is managed through a series of tables that can be modified by authorized staff. One limitation for the current UR system is an inability to review between two different claim types (e.g., review claims paid on an institutional claim form against claims paid on a professional claim form). Interviews with DHMH staff indicate that few staff are knowledgeable and experienced enough to employ new UR criteria or edit the existing tables. However, the staff maintaining the system is up-to-date with request fulfillment and the limited number of knowledgeable staff is not viewed as an obstacle for UR criteria implementation.

Monthly Managed Care Reconciliations

As monthly capitation payments to MCOs represent approximately 30 percent of Medicaid spending, DHMH staff several years ago engaged in increased efforts to ensure proper managed care capitation payment. One important strategy, made mandatory in September 2008, is an MCO reconciliation enrollment process.[11] In an automated monthly process, DHMH compares its enrollment data from the MMIS to the MCO's enrollment data. Any MCO with a discrepancy above a set threshold forfeits its right to participate in the financial portion of the reconciliation process. DHMH compares enrollment data to capitation payments to determine discrepancies in payments. The MMIS then produces a discrepancy report and payment adjustments.

The payment adjustment process for the Primary Adult Care (PAC) program differs from HealthChoice. The PAC process corrects for a known MMIS processing flaw. Because the aged MMIS architecture is designed to manage only one managed care benefit package, the MMIS will incorrectly close and retract payments when a beneficiary transitions between the two programs. DHMH conducts a primarily manual PAC reconciliation by reviewing the MMIS eligibility spans and individually determining the capitation payments owed to the MCOs. DHMH staff indicates that an automated system would reduce staff resources and reduce

[11] COMAR 10.09.65.15(c)(4)

delays in processing payments owed to the MCOs. The new MMIS will correct this processing problem.

While based on the reconciliation some plans returned funds to DHMH, the HealthChoice reconciliation process on net distributed $997,773 in additional funds to MCOs in fiscal year 2009. PAC adjustment payments to MCOs totaled approximately $6 million over the same period. DHMH staff report that in assuring proper payments to MCOs through these reconciliations, DHMH is improving MCO enrollment file accuracy to ensure that managed care enrolled beneficiaries have access to coverage.

Provider Documentation Review Contract

DHMH also contracts with a vendor to conduct documentation review at all Maryland inpatient hospitals as well as some outpatient hospital services. As of the most recent vendor procurement, the vendor is also contracted to review all claims paid to certain out-of-state hospitals. Using a series of algorithms, the vendor reviews paid claims and selects claims that have increased likelihood for resulting in error findings. For example, the vendor would review paid claims for evidence of service unbundling, likely coding errors, or possible duplicate payments.

After selecting the targeted claims, the vendor audits hospital itemized bills and requests and reviews medical records. Based on the requirements of the vendor's contract, in the post payment audit process, the contractor identifies discrepancies and overpayments, ensures that reimbursement is based on actual services rendered to patients, provides detailed accounting and verification of findings, and recovers monies owed to the State based on the findings. To recover funds, DHMH initiates a process by which overpayments are retracted from future provider reimbursements. State payment to the vendor is based on the extent of recoveries (i.e., a contingency contract) similar to the new federal requirement for states to procure recovery audit contractors (RACs).

We reviewed monthly reports as well as annual recovery totals from FY 2010 and the first quarter of FY 2011. Vendor reports indicate sampling and review of claims from hospitals across the State, as well as from six outpatient providers, were from claim year 2004. The FY 2010 annual report identifies $896,357 in recoveries. Interviews with DHMH staff attribute the delay in payment review and modest FY 2010 recoveries to vendor procurement problems with collection not beginning until nearly the last quarter of FY 2010. In reviewing the recovery reports from the first quarter of FY 2011, we found that recoveries in these three months have already doubled FY 2010 collections confirming DHMH staff assertions that FY 2010 totals are out of line with expected recoveries.

In addition, ACA requires that each state Medicaid program implement methodologies compatible with the National Correct Coding Initiative (NCCI) to promote correct coding and to control improper coding leading to inappropriate payment on all claims paid on or after October 1, 2010. DHMH contracted with the provider documentation review vendor to conduct

a post-adjudication review using NCCI editing for Maryland's professional claims.[12] Initial results indicate that MMIS is already programmed to meet most NCCI edits. DHMH has planned that when the provider documentation review vendor identifies areas for which additional editing is warranted, the contractor will provide the findings to DHMH for Department staff to implement new UR criteria.

Other Strategies to Reduce Claims Processing and Payment Errors

As documented in Appendix A, DHMH relies on a large number of other strategies to reduce claims processing and payment errors.

Analysis of the Extent and Causes of Claims Processing Errors

Identifying the extent and causes of claims processing errors is an issue of primary importance to DHMH as well as State and federal auditors. For the purposes of this project, we:

- Reviewed PERM findings from Maryland's most recent PERM cycles. We also reviewed the State's PERM corrective action plan.
- Conducted targeted analysis on a few key areas identified with DHMH, including identification of claims for beneficiaries that do not appear to have been eligible on the date of service, claims from providers that do not appear to have been enrolled on the date of service, and claims for beneficiaries that, it appears, should have been covered under a Medicaid managed care plan.

Extent of Claims Processing Errors

PERM Findings

The Payment Error Rate Measurement (PERM) program is a federally-mandated review of Medicaid and CHIP claims and eligibility. For the claims reviews component of the program, federal contractors select and review a random sample of FFS claims and managed care payments to calculate state and national payment error rates. A contractor conducts a data processing review (in Maryland, the review was conducted onsite at DHMH offices), as well as medical record review, of each FFS claim and a data processing review on managed care payments. CMS uses the findings from the review to calculate an annual payment error rate for the state and for the nation. States participate in the program every three years. Maryland first participated in PERM in the federal fiscal year (FFY) 2007 and is currently participating in the FFY 2010 review. ***Exhibit 4*** demonstrates that Maryland's error rates for both FFS and managed care were below the average national error rate for Medicaid in FFY 2007.[13]

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[12] Due to Maryland's Medicare Waiver, CMS has exempt Maryland Medicaid from the requirement to apply NCCI editing to institutional claims.

[13] Each FFY CMS calculates a national Medicaid error rate. The FFY 2008 error rate was 2.62 percent for FFS and 0.10 percent for managed care.

Exhibit 4: Comparison of National and Maryland PERM Findings

		National Rate, FFY 2007	Maryland Rate, FFY 2007
Medicaid	FFS	8.9%	1.04%
	Managed care	3.1%	0.00%

Note that PERM conducts random claim and payment sampling across the Medicaid and CHIP programs. The intention of PERM is to calculate an unbiased error rate. Therefore, unlike the provider document review vendor, PERM—by design—does not seek out areas of likely error for purposes of recoveries.

Any percentage of erroneous payments in a program as large as Medicaid results in millions of dollars of improper payments. However, the PERM findings suggest that the MMIS editing and UR criteria, coupled with a large number of other strategies such as DHMH's post-payment review processes, result in lower rates of claims processing and payment errors than other states have achieved.

Targeted Exploratory Analysis

As previously indicated, the scope of this project did not afford a comprehensive audit of claims payments. As a result, we worked with DHMH officials to identify targeted analyses that could potentially reveal errors in claims payments.

Beneficiary Enrollment Verification

Our first analysis was primarily intended as a data validation exercise to verify that paid claims could be successfully matched to individuals that were eligible for the Medicaid FFS program on the date of services. As expected, for more than 99 percent of claims, this was the case. However, we did identify approximately 12,085 claims with a total cost of $2.26 million that could not be matched to an eligible individual. As we understand that potential errors found in targeted exploratory analysis, such as this, will often not result in recoverable findings, we provided DHMH staff with a list of the identified claims for internal review and potential action.

DHMH staff conducted a detailed review of these claims and determined that the finding were not recoverable. A case worker incorrectly removed beneficiary eligibility spans (instead of "end dating" the spans). The claims indicated in this analysis were appropriately paid while the eligibility spans were in place in MMIS. DHMH's review of Lewin's findings identified a specific case worker responsible for creating a large portion of the errors and will refer the individual for training.

Provider Enrollment Verification

In a similar analysis we compared paid claims to a provider eligibility file to determine whether providers were, in fact, enrolled on the date that a service was provided. For most claim types including inpatient hospital, outpatient hospital, long-term care, specialist, pharmacy, and

home health, we confirmed that, for more than 99 percent of the claims, the provider was enrolled on the date of service. In our review of professional claims, we did identify a number of claims that appeared to not have an enrolled provider; however, upon review by DHMH staff, a vast majority of these were due to an administrative error in which a staff member inappropriately retrospectively ended a provider's eligibility. DHMH staff has corrected the administrative error. No funds should be recovered from the provider.

It is likely that the small number of claims paid without valid provider information may be due to out-of-date provider information on the MMIS provider file. DHMH is continuing to review the claims to confirm that provider information is accurate. When transitioning to the new MMIS, DHMH intends to conduct a complete provider reenrollment process and fully update all provider information.

FFS Claims for HealthChoice Enrollees

Lewin also analyzed managed care enrollment to determine if there were beneficiaries enrolled in HealthChoice who received services that were paid FFS that are not carved-out from managed care. Because we understand that some of these claims and costs may be justifiable based on payment rules, for example, for beneficiaries who enroll in HealthChoice during an ongoing hospitalization or for stoploss payments, we provided these claims to DHMH for follow-up. While DHMH staff review is ongoing, there are less that $6,000 in claims that may potentially be recoverable.

Services in Conflict

Several assisted living providers appear to have been paid for days of service even when a recipient was hospitalized, in violation of COMAR 10.09.54.16 and .33. These cases appear to warrant recoveries, and we have forwarded specific examples to DHMH for further review. We estimated the total value of the recoveries at $57,000 in 2009. DHMH staff has referred these cases to the DHMH Office of the Inspector General (OIG) for review. The cases also suggest potential value from establishing a recurring SURS or MMIS report on this service overlap.

Potential Causes of Claims Processing and Payment Errors

Potential causes of claims processing and payment errors fall into two major categories: claims processing errors and medical record or provider errors.

Claims processing errors usually occur when:

- Systems fail to operate
- System functions become out-of-sync with program policies. For example, if a program policy is adopted to limit the number of services for which the State will reimburse in a year, staff must initiate UR criteria or other edit in the MMIS to enforce the new policy
- Conflicting system editing or programming changes that are intended to apply only to a specific type of payment inadvertently impact other claims

Due to Maryland's antiquated MMIS architecture, the MMIS itself is a potential cause of claims processing errors. The technologies in Maryland's MMIS were not conceived to process the

types of payments—or even the volume of payments—processed today. Medicaid programs are increasingly more complex and proper claims reimbursement requires that thousands of business rules be translated into appropriate editing. Over the years, DHMH staff have modified the system innumerable times, often through work-arounds and "hard coded" programming. Such modifications are time consuming, difficult to audit, and, despite testing, have significant potential to result in unintended consequences.

Potential causes for medical record or provider errors are administrative mistakes, providers not aware or fully understanding State rules, and provider fraud.

Potential Strategies to Minimize Claims Processing and Payment Errors

Strategies to minimize claims processing and payment errors should be designed to address both system errors and medical record/provider errors. Below we describe some potential strategies aimed at reducing both types of errors. ***Exhibit 5*** provides a table of the identified strategies.

MMIS Procurement

The most obvious strategy for minimizing claims payment errors is the procurement of a new MMIS, a process which is well underway. By the time this assessment began, DHMH had already received proposals from MMIS vendors and had begun the review and selection process. We have also been informed by DHMH officials that the new system will incorporate edits based on national best practices, but customized to enforce Maryland-specific policies. The process for changing system parameters should also be greatly simplified to facilitate keeping the MMIS in-sync with program policies.

We believe that this is an important approach to minimize the potential for edits to perform unexpectedly. The cost for this effort has already been built into the MMIS development budget and it is reasonable to assume that increased automation and functionality may free up staff resources that can be redeployed in other areas.

While there is currently a significant backlog of customer service requests to fix problems with the existing system (152 as of October 1, 2010), DHMH appears to be effectively prioritizing these requests to focus on payment error prevention and significant policy changes. It does not appear that allocating additional staff to address the backlog would generate sufficient savings to be worthwhile before the new system is deployed in 2013.

Recovery Audit Contractor

The ACA requires states to have in place by December 31, 2010, a program to utilize the services of a Recovery Audit Contractor to identify payment errors and recover overpayments on a contingency basis. As discussed earlier in this section, Maryland already contracts with a vendor to review hospital and some professional claims. Later in this report, we discuss DHMH's vendor contract to review nursing facility claims. We note here that the federal RAC requirement may impact the future scope and strategy of the current vendor contacts. As these are contingency contracts, savings are identified without a significant upfront investment by the State.

Continuing Review of Areas Targeted for Analysis

While our analyses demonstrate that the number of potential errors is very low, they also demonstrate that a very small number of errors can have a significant fiscal impact. Based on the scope of this analysis, we were not able to independently determine whether the potential errors identified in the targeted analysis actually resulted in overpayments. DHMH continues to review these. However, if even a small proportion of these claims were paid in error, the potential savings could justify staff resources to investigate. We recommend that queries such as the ones that we performed be run on a periodic schedule and the results be tracked to indicate ongoing utility and ROI.

Exhibit 5: Projected Resource Requirements to Implement Claims Error Reduction Options

Option	Reg changes	New contracting	Additional staff time (need for re-allocation or new hiring)	Costs	Savings	Net ROI
MMIS upgrade		✓	✓	Level 3	Level 3	✓
RAC contractor		✓	✓	Level 1	Level 2/3	✓
Claims queries			✓	Level 1	Level 2	✓

All cost projections would require further analysis at DHMH based on more specific implementation plans. Savings are only achievable with the requisite investments indicated above. We categorized costs and savings as Level 1 (<$100k), Level 2 (<$500k), or Level 3 (>$500k). All are expressed as total funds.

4. Eligibility Payment Errors

Responsibility for Medicaid eligibility determination in Maryland is dispersed across several State and county departments with case workers employed at numerous locations throughout the State. Most program eligibility is determined by Department of Human Resources (DHR) staff generally located at Local Departments of Social Services (LDSSs) and stationed in hospitals through co-payment arrangements. In addition to determinations for other social programs (e.g., TANF, general public assistance, emergency assistance, federal food benefits, energy assistance and child care vouchers), DHR staff determines Medicaid eligibility for many traditional eligibility categories, such as the long-term care, aged, blind and disabled, families with children, and SSI-MA. The Local Health Departments (LHD) hold primary responsibility for eligibility determination for mail-in CHIP and Medicaid for Families applications. In addition, DHMH staff is responsible for eligibility determinations for PAC and Waiver Programs.

DHR staff process most of the Medicaid and CHIP applications. Since June 2010, DHR staff has processed 87 percent of all families with children applications, whereas the LDH staff has processed less than 13 percent. In the same time period for CHIP, which constitutes a much smaller proportion of total applications, DHR staff has processed 43 percent of applications, while the LHD staff has processed 57 percent.[14]

Most eligibility determination staff employs a centralized eligibility processing system, CARES, for determination of program benefits, including Medicaid. DHR owns and maintains CARES, but grants access to authorized staff employed by other agencies for Medicaid eligibility determinations. In a nightly data exchange process, CARES transfers eligibility information to the MMIS to provide eligibility information which is used for provider reimbursement and capitation payment.

Eligibility payment errors occur when a state makes an incorrect eligibility determination which then results in a subsequent claim or capitation payment. Examples of eligibility payment errors include services reimbursed for an individual:

- Ineligible when authorized or when he or she received services
- Eligible for the program but ineligible for certain services he or she received
- For whom the responsible agency lacks or maintains insufficient documentation to make a definitive eligibility review decision for the tested category or a different category under the program in accordance with the State's documented policies and procedures[15]

States across the country struggle to implement strategies aimed at minimizing eligibility determination errors and the resulting eligibility payment errors. In the FFY 2008 PERM cycle,

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[14] Data provided to Lewin by DHR

[15] We defined eligibility payment errors based on the PERM final rule: "Medicaid Program and Children's Health Insurance Program (CHIP); Revisions to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Program; Final Rule," 75 Federal Register 154 (11 Aug 2010), pp 44816-44852. Available Online <https://www.cms.gov/PERM/Downloads/Fin_Rule_Aug_1.pdf>

eligibility was a major driver of the total national Medicaid error rate. States, many with primary eligibility determination responsibility located outside of the Medicaid agency, often describe a lack of authority to influence the eligibility determination process as an impediment to implementing strategies to increase eligibility determination accuracy. Additionally, states cite potential sources of error due to chronic case worker staffing shortages. Compounding the staff shortages, case workers are tasked with workloads containing a growing number of programs with complex eligibility requirements, including substantial documentation verification. Additionally, states face numerous challenges stemming from aging eligibility determination systems and a lack of resources to modify and upgrade the systems, often resulting in workarounds and manual processes.[16]

Current Strategies to Reduce Eligibility Payment Errors

DHMH and DHR implement a variety of strategies to reduce eligibility payment errors. A discussion of these strategies follows, and an "inventory" of strategies is included in Appendix A. Much of our interviews and analysis focused on strategies that DHMH employs to reduce eligibility payment errors. However, as DHMH is not the primary agency responsible for a majority of eligibility determinations, overall strategies are limited in reach. Strategies at DHMH include:

- CARES-MMIS interface error reconciliation
- Eligibility case worker training
- Medicaid Eligibility Quality Control (MEQC)
- PERM

DHR also implements strategies to reduce eligibility payment errors. While we did not focus on obtaining a conclusive inventory of strategies implemented at DHR, the supervisory review of eligibility records is worth noting.

DHR operates an automated supervisory review system in which supervisors conduct three Medicaid reviews per case manager per month (unless the office has received a wavier). Between February 2010 and July 2010, supervisors reviewed 22,495 cases. DHR is also currently designing an automated "pre-review" strategy to move the timing of the case review from post-eligibility decision to pre-eligibility decision.

CARES-MMIS interface error reconciliation, eligibility case worker training, and the supervisory review of eligibility records are strategies designed to reduce eligibility payment errors prior to claims payment. MEQC and PERM conduct post-decision reviews in which the findings provide feedback that may be utilized to develop, target, and implement strategies to reduce future eligibility payment errors.

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[16] State of Minnesota Department of Human Services, "Current State Modeling and Analysis: 'As Is' Report," Health Care Connect Business Process Re-engineering Project. Available Online: <https://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5160-ENG>

CARES-MMIS Interface Error Reconciliation

Maintaining up-to-date, complete eligibility information in the MMIS helps ensure that the State makes payments only for eligible beneficiaries. DHMH receives a large majority of recipient eligibility information from CARES through a nightly data file interface with the MMIS.[17] During the nightly interface, CARES provides the MMIS with demographic and eligibility information for each recipient.

As DHMH is responsible for the integrity of beneficiary information in the MMIS, the Department has established a number of edits in the MMIS to intercept discrepancies between the MMIS and CARES and "kick out" problem cases for manual review onto certification turn around documents (CTADS). DHMH receives approximately 2,400 CTADS each week, all of which DHMH staff manually reconcile. ***Exhibit 6*** provides examples of the approximately 80 edits.

Exhibit 6: Examples of CARES-MMIS Interface Edits

Missing or invalid beneficiary name
Application date is not numeric
Duplicate SSN
Medicare ID change not allowed
Age/Coverage Group/Type mismatch
Coverage group requires a Medicare ID number
Coverage group is invalid/no longer active

DHR/DHMH Staff Training

DHMH staff is also involved in DHR and DHMH case worker trainings for Medicaid eligibility. DHMH provides training both in written format and by conducting in-person trainings. Written training materials, often developed in response to a policy change or new program implementation, are provided to case workers as bulletins and CARES instruction statements. To facilitate training in response to policy changes, the DHMH eligibility training unit, consisting of four trainers and a supervisor, is organized to report to eligibility policy staff within DHMH.[18] Department staff may also develop written trainings when eligibility reviews indicate areas in which trainings may increase correct eligibility determinations.

DHMH also provides trainings as part of CARES new worker orientations. In addition, DHR supervisors have the ability to require case workers to attend repeat trainings. DHMH participates in these training sessions as well. Since January 2010, DHMH has provided more than 200 trainings which consist of both class room and on-site trainings.

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[17] Eligibility data for the Primary Adult Care, MCHP Premium, Employed Persons with Disabilities, and the Breast and Cervical Cancer programs is maintained independent of CARES. DHMH staff manually enters beneficiary information into MMIS.

[18] Some positions are vacant at the time of writing this report.

To improve the trainings, DHR and DHMH training staff recently met to discuss ways to improve the training. Staff from both departments are also working together to develop a Basic Eligibility Staff Training Comprehensive training program.

Medicaid Eligibility Quality Control (MEQC)

The federal government requires that each state implement a Medicaid eligibility quality control (MEQC) program to address erroneous expenditures in the Medicaid program due to eligibility determination errors. States are required to conduct MEQC activities each year and produce a MEQC error rate every six months. States have the option to conduct either a "traditional" MEQC program or a pilot. The "traditional" approach requires that states select a random sample of active cases (defined as an individual or family determined to be currently authorized as eligible for Medicaid by the agency) and negative case actions (defined as an action that was taken to deny or terminate Medicaid coverage) from a universe of all active cases and negative case actions in the Medicaid program. The state then reviews the cases to determine if eligibility was correctly granted or denied/terminated and associated dollars with each sampled case are identified so that the state can calculate a payment error rate.

As an alternative to the traditional approach, the federal government allows several states, including Maryland, to implement MEQC pilots. Under a pilot program, states are allowed to identify a targeted area in which to focus review efforts rather than sample from the total Medicaid case universe. Over the years, Maryland has conducted a number of different pilot MEQC program that have focused on specific eligibility categories, waiver programs, and other focused areas such as spend-down cases. The State's most recent pilot program focused on long-term care recipients.

As implemented in Maryland, MEQC does not enumerate the extent of eligibly payment errors across the program, but instead annually lends insight to root causes and patterns of errors in focused areas allowing the State to perform targeted training to correct issues as they are identified.

Payment Error Rate Measurement (PERM) Eligibility Review

For the eligibility component of PERM, states are responsible for selecting and reviewing a random sample of eligibility cases to calculate state and national payment error rates. States must randomly sample eligibility cases, defined as an individual from a universe of all cases currently receiving Medicaid benefits. States are responsible for identifying the payments used in the calculation of the payment error rate which are payments made for services received in the sample month for each sampled case and paid in that month and the following four months. A PERM eligibility payment error occurs if a case is determined to have one of the following error codes: not eligible, eligible with ineligible services, liability overstated, liability understated, or a managed care error. Additionally, a case with a finding of "undetermined," in which a state is unable to verify that an individual was eligible, is also considered an error in the PERM payment error rate calculation. The federal contractor uses the error rate data to calculate a state-specific and a national payment error rate. States participate in PERM every three years.

Following determination of eligibility payment errors and error rates, states design solutions to reduce improper payments based on its analysis of causes of identified errors.

Maryland first participated in PERM in FFY 2007 and is currently involved in the FFY 2010 PERM cycle.

Analysis of the Extent and Causes of Eligibility Payment Errors

The PERM process already measures eligibility error rates through a valid, federally-endorsed process. Therefore, rather than replicate any broad-based error measurement, we chose to further analyze the most recent PERM eligibility error measurement and to conduct targeted analyses in an area with potential to appropriately shift costs from Medicaid to Medicare.

Extent of Eligibility Payment Errors

PERM engages in a broad-based sampling and review and – with considerable state effort – enumerates Medicaid and CHIP eligibility payment errors for each state every three years. Maryland's FY 2007 Medicaid active case payment error rate was 7.71 percent.[19] The State had 49 Medicaid errors (out of a sample of 504 cases selected over the fiscal year) with 17 cases found to be "not eligible" and 32 cases that were "undetermined." The "undetermined" designation was cited for cases in which the State was unable to determine whether a beneficiary was appropriately given Medicaid coverage based on case documentation within the PERM review guidelines.

Federal regulations promulgated after the 2007 review changed the way CMS treats the "undetermined" cases, with the result that fewer such cases are now counted as errors. We obtained undetermined cases from the 2007 review to assess whether the new regulations would have led to a different error rate in 2007 had they been in effect. However, the cases that were "undetermined" had no impact on the overall 2007 Medicaid eligibility payment error rate because no dollars were identified as having been paid for services received in the sample month for any of the sampled cases found to be undetermined.

Other review processes such as MEQC, have calculated different error rates for specific types of eligibility determinations. However, these processes do not necessarily use the same sampling and weighting techniques as PERM.

Targeted Exploratory Analysis – Elderly Beneficiaries without Medicare Coverage

The vast majority of people age 65 and older are eligible and enrolled in the federally-funded Medicare program. Medicare has three main categories of coverage. Part A covers inpatient hospital care, skilled nursing care, home health services, and hospice care. Part B covers physician services and outpatient care, and Part D covers prescription drugs. Anyone who has worked and paid Medicare taxes for at least 10 years or has a disability and was covered by Medicare prior to age 65 is eligible to receive Medicare Part A at no cost when they turn 65. A person who did not work, but who has a spouse eligible for Medicare, is also eligible for

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[19] The error rate calculation is weighted based on the dollar value of claims associated with the erroneous determinations.

Medicare Part A. People who are not eligible for Medicare Part A can purchase Part A coverage for $450 per month.

Anyone who is eligible for Part A is also eligible for Part B. However, Part B is an optional program, and Medicare beneficiaries must pay a monthly premium of $115.40 to receive Part B. Most state Medicaid programs, including Maryland's, provide assistance to people enrolled in both Medicaid and Medicare (i.e., dual-eligibles) to cover the costs associated with Part B coverage.

State Medicaid programs have a financial incentive to identify and promote Medicare coverage because Medicare coverage reduces the financial burden on the states for services like inpatient hospitalizations, physician services, and many others.

Maryland Non-dual Medicaid Beneficiaries Over Age 65

Our analysis of annual Medicaid enrollment statistics from FFY 2008 finds that Maryland has a higher share of Medicaid beneficiaries who are 65 or older who do not have Medicare coverage than the nation and other states in its region. ***Exhibit 7*** compares the share of elderly Maryland Medicaid beneficiaries without Medicare coverage to the United States. The table shows that 11.1 percent of elderly Maryland Medicaid beneficiaries do not have Medicare coverage compared to only 7.7 percent of elderly Medicaid beneficiaries nationwide.

Exhibit 7. Share of Medicaid Enrollees Age 65 or Older without Medicare – National Comparison

	Medicaid Enrollees Age 65 or Older	Medicaid Enrollees Age 65 or Older without Medicare	Share of Medicaid Enrollees Age 65 or Older without Medicare
United States	6,020,020	460,847	**7.7%**
Maryland	73,139	8,125	**11.1%**

Source: 2008 Monthly State Summary, Medicaid Statistical Information System (MSIS) State Summary Datamart

Even compared with other states in the mid-Atlantic region, Maryland holds the highest percentage of Medicaid recipients over age 65 without Medicare coverage. Only six states in the United States have higher rates.

Claims Experience for Non-dual Medicaid Beneficiaries Over Age 65

We analyzed state FY 2009 paid claims associated with recipients who were 65 years or older on the date they received a Medicaid covered service, and we merged Medicaid claims with the eligibility file to determine the Medicare eligibility status of a member during the month they received a service. Similar to the MSIS results presented above, our analysis indicates that there are approximately 7,100 Medicaid beneficiaries age 65 or older who are citizens or legal residents of the United States but are not covered by Medicare. We understand that Medicare eligibility is based on a number of criteria in addition to age, and that some portion beneficiaries identified in this targeted analysis will never be Medicare eligible.

Through our analysis, we found a small number of claims for which the recipient was not flagged as Medicare-enrolled in the eligibility system but for whom Medicare paid a claim (and Medicaid paid cost sharing). For these claims, Medicaid expenditures were no different than they would have been had the eligibility system shown Medicare eligibility, because the provider billed Medicare directly. However, the Medicare payment suggests that there are potential inaccuracies in the Medicare eligibility data.

Exhibit 8 summarizes our analysis for inpatient claims only (see Appendix B for additional analysis on inpatient and other claims). We identified 66 claims (associated with 48 different beneficiaries) in FY 2009 where a Medicaid beneficiary was reported as not eligible for Medicare but had a claim for Medicaid cost-sharing that indicated Medicare payment. Once again, Medicaid payment for these 66 claims was no different than if the recipients were properly identified as Medicare eligible. However, four of the 48 beneficiaries subsequently received inpatient hospital services for which Medicaid was billed rather than Medicare. In 2009, these instances account for 18 different claims and a total cost of $206,227. Based these findings, DHMH staff will implement a SURS algorithm or periodic MMIS report to identify cases such as these for further review.

Closer investigation of these cases can determine if recoveries are warranted. However, it is important to note that they were identifiable only because providers had previously billed Medicare and triggered Medicaid cost sharing. It is possible that there are other beneficiaries that are Medicare eligible but for whom the provider only billed Medicaid. For example, we found, in state FY 2009, 3,956 claims for inpatient hospital and hospice services for beneficiaries age 65 or older and citizens or legal residents of the United States who are not identified as Medicare-eligible and for whom Medicare did not make a payment on the claim. The cost of these services for the Medicaid program was $36.4 million.

Exhibit 8: Eligibility in Month Service Provided vs. Medicare Claims Coverage and Reimbursement Amounts

Month Medicare Eligible	Medicare Covered	Number of Claims	Percent	Medicaid Reimbursement Amount	Amount Paid by Medicare
No	Covered	66	0.22 %	$107,424	$1,094,450
No	Not Covered	3,956	13.02 %	$36,440,611	$0.00
Yes	Covered	17,844	58.76 %	$19,678,091	$187,801,490
Yes	Not Covered	8,502	28.00 %	$50,117,836	$0.00

Currently, DHMH receives Medicare entitlement information directly from the CMS. This information is received through a monthly data file exchange and entered into MMIS. Staff is specifically dedicated to resolving discrepancies to ensure Medicare information is accurately uploaded into MMIS. DHMH also forwards beneficiary eligibility information to the Medicare vendor on a daily basis to assist in the identification of claims that Medicare should pay. DHMH also has the capability to recover monies paid to providers if Medicare entitlement is established retroactively.

It is not clear from this analysis whether a broad effort to buy more individuals into Medicare coverage would be cost effective. However, further focus appears warranted, starting with the small number of individuals for whom Medicare payment suggests that they are truly Medicare-enrolled and for whom other Medicaid inpatient payments may have been more appropriately billed to Medicare.

We present more detailed analysis in Appendix B.

Potential Causes of Eligibility Errors

There are numerous causes of eligibility errors. One of the fundamental causes is the complexity and dynamism of Medicaid itself. Eligibility is inherently complicated, and new programs added over the years have added complexity to an already challenging process. However, beyond the nature of Medicaid itself, the causes of errors fall into two general categories:

Staffing and training. In its corrective action plan for PERM, DHMH cited "systemic staffing problems exacerbated by increased caseloads, and high staff turnover" as the root cause of many errors. (This problem is not unique to Maryland.)

Technology. As with the MMIS, the CARES system is based on legacy technology that can be cumbersome to work with and challenging to modify. CARES' shortcoming are compounded, however, by a backlog of programming requests related to CARES or the CARES-MMIS interface. For example, while DHMH has submitted customer services requests to DHR to initiate corrections in CARES, Department officials indicate that DHR's prioritization of CARES programming corrections have not been fully implemented due to funding and other resource constraints. Currently, there are 29 outstanding CARES customer services requests, some dating back to 2005.

Due to programming delays in CARES, DHMH established a number of edits in the MMIS to intercept discrepancies between the MMIS and CARES and "kick out" problem cases for manual review onto certification turn around documents (CTADs). The Office of Eligibility receives approximately 9,000 CTADs each month, all of which the Department works manually.

Strategies to Minimize Eligibility Payment Errors

The ACA will force all states to fundamentally restructure their eligibility systems to meet requirements related to health insurance exchanges, Medicaid, and other public programs. DHMH and DHR will have unprecedented challenges and opportunities in the coming years to dramatically rethink the organizational structure, processes, and technological infrastructure for the eligibility system.

Within this context, there are both immediate investigatory steps and long-term structural opportunities to reduce eligibility errors. We describe options below. ***Exhibit 9*** provides a table of the identified strategies.

CARES Improvements

Many eligibility errors could be prevented or mitigated through improvements to the CARES system. CARES does not allow for the types of sophisticated edits that could reduce the

frequency of problems when claims hit the MMIS. 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.

Training Enhancements

Training has a direct impact on eligibility payment errors. Enhanced equipment and software could provide online Webinar training, policy learning modules, and periodic quizzes. These technologies could expedite training (e.g., provide targeted learning modules in conjunction with policy changes on the day a change is implemented) thus reducing possible eligibility determination errors. In addition, technologies may achieve potential cost savings by decreasing travel expenses. DHMH and DHR combined have spent in excess of $150,000 in travel expenses to-date during 2010.

DHR Staffing and Backlog of Service Requests

To reduce eligibility errors, DHR would need to add more caseworkers, supervisors, programmers and other staff to address the two fundamental problems described earlier in this chapter: chronic understaffing among eligibility workers and a backlog of unfulfilled CARES programming requests from DHMH to DHR. Staffing increases at DHR could reduce staffing demands at DHMH by reducing the need for CTADs and other manual reviews. (As a positive step, DHR is implementing a workload standards study in FY 2011.) Return on investment from staffing increases is difficult to quantify, but it would almost unquestionably reduce eligibility errors, improve timeliness of eligibility decisions, and improve overall customer service.

DHMH Staffing and Potential Cost Savings

Lewin's targeted analysis identified approximately 7,100 Medicaid recipients age 65 and older who are citizens or legal residents of the United States but not covered by Medicare. DHMH might achieve some cost savings by hiring additional staff to perform outreach to beneficiaries that may enroll in Medicare.

Review Payments Identified in Targeted Analysis

We identified a small number of claims that suggest specific beneficiaries are enrolled in Medicare but do not appear as such in MMIS. In a few instances, Medicaid paid for services for which there is a high probability that Medicare should have been the primary payer. These cases warrant immediate investigation (and the small volume of claims should make this follow-up administratively manageable). Pending that investigation, 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 the MMIS as Medicare-enrolled.)

These claims, together with evidence that Maryland has an above-average percentage of elderly Medicaid beneficiaries without Medicare coverage, suggest that there may be eligibility errors or insufficient processes to facilitate Medicare buy-in. The topic may be a good candidate for a future MEQC review or other investigative efforts.

Develop Automated Processes to Replace Manual Transactions

Monthly, DHMH performs 9,000 manual transactions to activate eligibility or modify coverage for eligibility categories not included in CARES or for which CARES does not properly edit. DHMH engaged in a time study process to determine if it would be cost effective to develop some limited automated MMIS updating capabilities. After a review of the time study report, DHMH identified manual processes for updating MMIS that have the potential for automation. One automated process that has been implemented recently converts newborns into the correct coverage group when they are a year old. This automation reduced the number of manual transactions by 10 percent. Other processes in development include hospitals obtaining a newborn's Medical Assistance number by accessing E-Medicaid and an automated adjustment to ensure proper reporting of federal financial participation funds. Automation of these processes could significantly reduce the number of manual transactions that DHMH can complete.

Review Cases Indicated in PARIS Match

DHR participates in the Public Assistance Reporting Information System (PARIS), which is a federal-State partnership to assist in enrollment data exchange between the federal agencies and states and among the states. Data may be used to verify beneficiary income and used to determine if Medicaid enrolled beneficiaries may be eligible for federal health programs. PARIS data may be used to identify beneficiaries no longer residing in Maryland by identifying individuals receiving program benefits in other states. On average, DHR staff process more than 500 Medicaid matches per month; however, more than four times that number are awaiting action by staff. Further review of PARIS data by DHR or DHMH staff may reduce eligibility payment errors by identifying beneficiaries with access to federal health benefits or for whom Medicaid should no longer provide coverage.

Exhibit 9: Projected Resource Requirements to Implement Eligibility Error Reduction Options

Option	Reg changes	New contracting	Additional staff time (need for re-allocation or new hiring)	Costs	Savings	Net ROI
CARES improvements		√	√	Level 3	Level 3	√
Training enhancements			√	Level 1	Level 2	√
DHR staffing and backlog			√	Level 3	Level 3	√
DHMH staffing and potential cost savings			√	Level 1	Level 2	√
Review payments identified in targeted analysis			√	Level 1	Level 2	√
Develop automated process to replace manual transactions		√	√	Level 1	Level 2	√
Review PARIS matches and calculate enrollment savings			√	Level 2	Level 3	√

All cost projections would require further analysis at DHMH based on more specific implementation plans. Savings are only achievable with the requisite investments indicated above. We categorized costs and savings as Level 1 (<$100k), Level 2 (<$500k), or Level 3 (>$500k). All are expressed as total funds.

5. Utilization Review

Current Utilization Review Strategies

Utilization review (UR) is the process of evaluating the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.[20] In this report, we focused on UR as a retrospective, post-payment process.

Broader terms like "utilization management" or "utilization control" encompass UR, pre-payment activities (e.g., prior authorization), medical eligibility requirements, and service limitations. DHMH undertakes many pre-payment review activities which are discussed above to reduce claims processing errors.

Federal regulations require that states establish systems for utilization control, including post-payment utilization review, at 42 CFR 455 and 456. However, states have latitude to customize their approaches to UR.

Utilization review, as we are conceptualizing it in this report, does not inherently save money. Instead, it helps identify over- or under-utilization of services that may indicate inappropriate billing, recipient misuse of services, and/or opportunities for improved coordination of care. Therefore, the success of UR activities is dependent on both smart utilization review and rigorous follow-up.

DHMH manages numerous post-payment UR activities carried out by MCPA staff, contractors, and the Office of the Inspector General. An inventory of existing UR strategies is included in Appendix A. We highlight a selection below.

Medicaid Utilization Control Contract

Medicaid's Office of Health Services maintains a contract with an external vendor to perform several utilization management and utilization review functions related to hospital, nursing facility, and HCBS waivers. ***Exhibit 10*** discusses select activities in the utilization control contract. The contract was rebid during 2010.

Exhibit 10: Selected Activities in Utilization Control Contract

Hospital Services	Nursing Facility and HCBS
Acute care hospitals o Pre-admission review of elective admissions o Pre-authorization of certain hospital services (e.g., organ transplants) o Concurrent review for the medical necessity/appropriateness of ongoing hospital stays o Retrospective review of medical	**Nursing facilities** o Assess whether individuals meet (or continue to met) Medicaid nursing facility level of care criteria o Screen potential nursing facility residents for mental illness or developmental disabilities o Review records to determine appropriateness of billing for discrete services billed to

[20] U.S. National Library of Medicine. Available Online: <http://www.nlm.nih.gov/nichsr/edu/healthecon/glossary.html>, Accessed 11 Oct2010.

necessity/appropriateness of certain pre-authorized elective admissions, emergency admissions, and retroactive admissions **Chronic hospitals** o Assess whether individuals meet (or continue to meet) Medicaid hospital level of care criteria	Medicaid by nursing facilities (e.g., decubitus ulcer care) **HCBS** o Assess whether individuals meet (or continue to meet) Medicaid level of care criteria o Validate medical records at a sample of medical day care centers

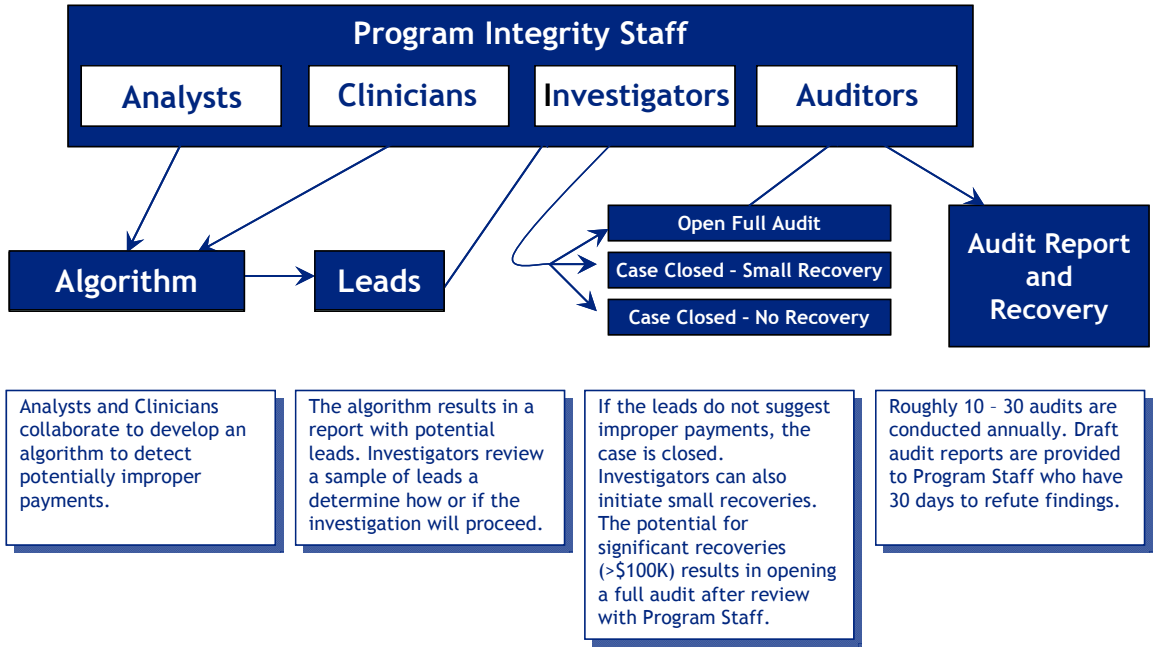
Division of Program Integrity and SURS

The Division of Program Integrity is located within the DHMH OIG and is charged with identifying cases of actual or potential fraud and working with program staff to recover inappropriate payments. The Division of Program Integrity also has some responsibility for payment error prevention through provider training and by recommending edit creation or revision to enhance the ability of the MMIS to prevent errors.

Several program integrity functions and staff were transferred from MCPA to the OIG in 2006. The Division of Program Integrity consists of 32 staff, 24 of who work primarily in provider reviews, while the remaining 8 work in recipient reviews and special projects. Beginning in FY 2011, the Division received approval to hire additional clinical staff and currently the Division has positions for 4.5 nurses and 1 pharmacist. OIG has been charged with identifying $20 million annually in improper payments, including recoveries from the Medicaid Fraud Control Unit.[21]

The Surveillance and Utilization Review Subsystem (SURS) of the MMIS is an important tool that the Division of Program Integrity uses to identify potentially improper payments. The SURS stores Medicaid claims data and allows analysts to detect problems through trends in billing. The systems can also provide evidence of problems in the quality of care delivered and can help inform program policy decisions. The following graphic demonstrates the progression of a typical case.

[21] It is important to note that there is no consistent methodology across states for calculating program integrity savings. Therefore, we did not attempt to benchmark savings totals.



PI staff indicates that the Division of Program Integrity consistently analyzes processes and outcomes in order to adapt to rapidly changing fraud schemes and overpayment vulnerabilities. For example, Division staff indicated that they are in the process of developing a database of algorithms and a schedule for running them, but this is not yet in place. The database improves upon an older, less effective SURS model and will allow for functions such as a "tickler" system to indicate when staff should rerun successful algorithms.

Unfortunately, due to the limited functionality in the current SURS interface, it was difficult to establish a clear indication of the types of SURS reviews routinely performed.

Program Monitoring

Program staff within MCPA has an ongoing responsibility to monitor service utilization and expenditures for the programs they oversee. This is accomplished through a variety of utilization review mechanisms, including ad hoc reporting, claims review, and – in some cases – actual utilization controls. Budget monitoring is primarily done through a monthly report known as the "Stat Pack" that is used to identify spikes in billed units of service.

While UR activities take place in nearly all program areas, they are more prominent for services that are especially vulnerable to potential fraud and abuse, such as pharmacy and durable medical equipment (DME). DME staff monitor their program through a variety of reports that identify claims paid for individuals that are potentially ineligible for services, including individual that are deceased, institutionalized, or lack an appropriate clinical diagnosis.

The pharmacy program performs both prospective and retrospective UR activities including claims review for specialty drugs and very high-cost claims. A drug utilization review (DUR) vendor, Health Information Designs (HID), identifies cases for potential clinical intervention and recommends potential policy revisions and/or creation of edits to prevent future inappropriate billing. HID administers a DUR Board as well as a Corrective Managed Care

program that reviews utilization of FFS beneficiaries and can "lock" potential prescription drug abusers into obtaining medications only from pre-approved pharmacies.

HealthChoice MCOs

In addition to UR activities conducted within DHMH, managed care organizations that participate under HealthChoice are required to conduct their own UR activities. The MCOs have "written utilization management plans that describe procedures to evaluate medical necessity criteria used, information sources, procedures for training and evaluating staff, monitoring of the timeliness and content of adverse determination notifications, and the processes used to review and approve the provision of medical services."[22] In addition to promoting high-quality care, these activities are expected to reduce inappropriate payments which should ultimately accrue to the State of Maryland in the form of lower premium payments.

Claims Analysis Related to Utilization Review

We conducted several analyses to determine whether additional utilization review efforts may be warranted based on apparently aberrant patterns in utilization. These analyses focused on several high-cost program areas that are prone to overuse, including inpatient hospitalization, emergency room use, prescription drug use, and long-term care services provided in recipients' homes.

Analysis of Emergency Room, Physician, and Prescription Drug Utilization

We examined utilization of ER visits, physician services, and pharmacy services among FFS Medicaid members during fiscal year 2009. ***Exhibits 11 and 12*** summarize utilization for these services, with deeper analysis presented in Appendices C, D, and E. Our analyses indicate that in Maryland – as in any state – there are individuals who stand out as outliers with extraordinarily high utilization of services. Our analysis suggests that:

- There are likely some individuals are exhibiting inappropriate drug-seeking behavior by seeking services from a wide range of pharmacies, ERs, and physicians despite not having diagnoses for high-acuity health conditions. Separating those engaged in recipient fraud from those with complex needs and poorly coordinated care, however, would require additional investigation and resources.
- There may be opportunities to reduce service utilization by working with current case managers. Achieving a positive return on investment in care management programs, however, requires careful targeting of resources, and – based on our analyses in Maryland – would require a strong focus on behavioral health services.

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[22] Medicaid Managed Care Organization System Performance Review, Statewide Executive Summary, Final Report for CY 2009. Available Online: <http://dhmh.maryland.gov/mma/healthchoice/pdf/2009/CY2009_Statewide_Executive_Summary_FINAL.pdf>

Exhibit 11: Pharmacy Utilization[23]

High Utilizers	Prescriptions
Total FFS volume	2,646,169 fills
Unduplicated beneficiaries	202,950
FFS cost	$305.6m
95th percentile	49 fills

Exhibit 12: ER and Physician Utilization

High Utilizers	ER Visits	Physician Visits
Total FFS volume	133,054	766,180 visits
Unduplicated FFS members	71,651	157,418
FFS cost	$51.7m	$42.5m
95th percentile	5 visits	16 visits

Potential Utilization Review Strategies to Employ

While there are a variety of existing utilization review strategies in use, opportunities exist to enhance the effectiveness of these strategies and to add additional activities that could potentially help contain costs. ***Exhibit 13*** provides a table of the identified strategies.

Interagency High Cost Case Review Team

DHMH should establish a clinical review team to monitor and investigate high-cost users of Medicaid services. Currently, there is no systematic process in place for assessing high-cost cases outside the boundaries of individual programs. This interagency team would intervene where appropriate on a case-by-case basis and based on these investigations, would identify broader policy problems and solutions.

As our analyses demonstrate, there are many instances of high service use that the team might address. Though some instances may be justified, they do warrant careful attention. For example, if a high-cost beneficiary was enrolled in a waiver program, the team might contact the individual's case manager or service coordinator and primary care provider to review the beneficiary's plan of care and clinical information. The team might also contact other providers to determine how they coordinate services and what types of special services may be in place for the individual. If all services appear to be appropriate, the review may end without further action. Otherwise, the team may recommend changes to the care plan, further investigation and monitoring and/or refer the case to program integrity staff. During this process, the team

[23] Pharmacy utilization figures represent all prescriptions paid FFS. This includes both FFS beneficiaries (including individuals in nursing facilities) and beneficiaries enrolled in managed care who receive certain prescriptions through FFS Medicaid.

would consider relevant policy issues which might include the adequacy of case management and care planning processes and whether changes to program policies should be considered.

To establish an effective clinical review team, the state must identify and devote appropriate team members and support staff to coordinate the initiative. The team should include individuals with clinical expertise, representatives from the policy and program integrity staff as well as from the Developmental Disabilities Administration and the Mental Hygiene Administration. A capable analyst or support staff member who can plan meetings, identify cases, follow through on team recommendations and report to leadership is also essential. The group would have to define its mission, identify its priorities, develop a work plan with roles and responsibilities and establish a meeting schedule. Since the team would operate in concert with existing rules and regulations, the state would not have any legal or regulatory issues to address.

Collaboration between PI/SURS and Programs

MCPA and the Division of Program Integrity should take additional steps to promote coordination and collaboration. Utilization review is – and will continue to be – a shared responsibility of program staff and OIG staff. Currently, however, the level of collaboration is not as strong as it needs to be to optimize administrative efficiency and Medicaid savings.

Steps have been taken to address this concern. For example, OIG staff now meets with Medicaid staff prior to opening a full audit. This allows Medicaid staff the opportunity to provide feedback on assumptions and methodology prior to expending resources on the audit. Other concrete steps could include:

- Active collaboration in priority-setting for an annual strategic plan (see recommendation below)
- Greater transparency on the program integrity and surveillance activities, including broad-based SURS runs, that have been completed by PI staff
- Greater use of SURS functionality by MCPA staff
- Outreach and education by PI staff to MCPA Division Chiefs that have not requested any SURS analyses

Program Integrity Strategic Planning

The Department should develop an annual strategic plan for UR activities. No current plan exists, and this reduces the chances that UR activities are conducted deliberatively, strategically, and efficiently. This plan should include the development of algorithms to detect potential anomalies, investigation of cases identified by these algorithms, a mechanism to track the success of each algorithm, and a plan for re-running algorithms that prove successful. OIG intends that the database in development will serve as a foundation for evaluating current strategies.

The Division of Program Integrity may be the logical "owner" of the strategic plan, but it should be jointly developed with MCPA leadership and MCPA program staff, with both Medicaid the

OIG agreeing to the plan. (It should also reflect input from DDA and MHA.) The plan itself need not be a lengthy document, but should be a vehicle for:

- **Priority-setting.** The plan should synthesize input from program staff, PI experts, and best practices from other states. It should be the platform for re-evaluating the effectiveness of past analyses and proposing new ones. These priorities should not constrain PI or MCPA staff from pursuing ad hoc investigations during the year.
- **Clarifying roles and responsibilities.** It should specifically identify who will perform which types of UR functions.
- **Establishing accountability.** The plan, revisited throughout the year, would be basis for clarifying accountability – both within MCPA and OIG – for the purposes of successful project management.

Hiring Additional Staff Across Medicaid to Engage in PI Activities

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. Ideally these staff would be organized into work units that could focus on specific groups of providers (e.g. institutional, professional, waivers), allowing staff to eventually "master" the policies that relate to their area of specialization. The Department would also benefit from additional clinical staff, beyond the current 4.5 nurses and one pharmacist that are qualified to assess medical necessity and clinical effectiveness.

Across the Department, DHMH staff report understaffing due to increased program requirements at the State and federal level coupled with budget constraints resulting in hiring freezes. Even key staff positions many go unfilled for extended periods. A complete review of Department staff may indicate areas for which hiring additional staff would allow subject area experts already in the Department to reallocate time to program integrity functions (as well as to implement suggestions as described in this report).

Strengthen Utilization Review Requirements and Incentives for HealthChoice MCOs

Generally speaking, HealthChoice MCOs have an intrinsic incentive to review and manage service utilization, because the MCOs receive capitated payments. However, provider-sponsored MCOs may have other financial considerations, and our own experience working with health plans suggests that – financial incentives notwithstanding – there is room for improvement on detecting and remediating over-utilization of services.

- **Reframe HealthChoice performance measures**. Current performance measures for HealthChoice MCOs focus on increasing utilization of certain ambulatory care and preventive services.[24] If stronger focus on MCO UR activities is an objective, the Department can reframe some of the performance measures toward reduction of undesirable high-cost service utilization. Examples could include reduced ER utilization,

[24] COMAR 10.09.65.03. Available Online: <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.65.03.htm>, Accessed 13 Oct 2010.

risk-adjusted hospital readmission rates. Unlike other states, though, Maryland regulates hospital rates for all payers through the Maryland Health Services Cost Review Commission (HSCRC). The HSCRC is working on ways to reduce readmission rates across all hospitals.

- **Focus performance improvement plans on reducing utilization of avoidable high-cost services**. Similarly, DHMH can work with MCOs to target the performance improvement plans required under 42 CFR 438.240 on effective UR and follow-up activities to reduce undesirable utilization of high-cost services.

Strengthen Utilization Controls

Electronic Verification for In-home Services

The delivery of in-home services is difficult to monitor, presenting providers with opportunities to bill for undelivered services or pad their hours to bill for incrementally more than actually delivered. Multiple states, including Oklahoma, South Carolina, and Tennessee, have implemented electronic verification systems to track when providers are actually present in a Medicaid recipient's home. These systems generally require that providers call from the recipient's home phone when they arrive and when they leave. Voice recognition software then confirms the providers identify or flags the recording for review. The systems also serves as a time clock to calculate the actual hours of service and can alert provider agencies and government officials when providers do not arrive on time.

The evidence base for the savings associated with these systems is not robust. However, states believe that the systems are achieving savings.[25] The systems can be expensive to develop and implement, but 90 percent FMAP is available for much of the development cost due to tie-ins with the MMIS, and other grant funding may help offset implementation costs.

Corrective Managed Care Program

As demonstrated by our claims analyses, a small number of beneficiaries use an extremely high amount of prescription drugs. Our analysis of prescription drug claims showed that the top one percent of prescription drug users filled an average of 111 prescriptions in the year.[26] Further, high utilizers of ER services, almost half of whom had low acuity conditions, received almost 6,000 prescriptions for pain, anxiety, and depression medications.

Such high use of prescription medications, including by relatively low acuity individuals, could potentially be mitigated by increased utilization controls. For example, further analysis of this population is recommended to determine if these members should be enrolled in the Pharmacy Corrective Managed Care Program to reduce prescription drug costs. Under this program, recipients are required to obtain prescription medications from one predetermined pharmacy.

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[25] See, for example, "South Carolina's Care Call." Available Online: <http://www.cshp.rutgers.edu/Downloads/6800.pdf>.

[26] These may be for very sick individuals who require a large number of prescriptions. Additionally, prescriptions counts do not consider the timeframe of the prescription (e.g., one prescription may be for a month of dosing, a day of dosing, a week of dosing, etc.).

It is our understanding that, while the Corrective Managed Care Program for the FFS population does exist, there are currently no Medicaid beneficiaries enrolled in the program. For HealthChoice enrolled beneficiaries, there are two components to pharmacy lock-in programs. First, there are prescriptions paid by the MCO. Regulations permit MCOs to establish lock-in programs and 4 out of 7 MCOs currently have lock-in programs. Second, HealthChoice enrolled beneficiaries receive certain prescriptions (mental health and HIV/AIDS drugs) outside of the MCOs. Like other FFS prescriptions, carved-out pharmaceuticals are initially adjudicated through a point of sale (POS) pharmacy vendor's claims payment system. Currently there is no mechanism in the POS claims processing system to allow DHMH staff to lock-in HealthChoice enrolled beneficiaries for the carved-out prescriptions paid FFS.

If further investigation by DHMH staff indicates that high drug utilization tends to be due to carved-out services, we advise reviewing opportunities to lock-in this population for carved-out services and possible liberalizing lock-in criteria to facilitate enrollment.

While the size of populations already enrolled in managed care may differ, other states have had success with lock-in programs. Missouri's Medicaid has over 1,400 individuals enrolled in its Administrative Lock In program with only two staff needed to oversee the program. As other examples, Kansas reports 362 enrollees in their lock-in program; while Florida reports less than 175.

While increased emphasis on lock-in would necessitate hiring staff to manage a larger program, if Maryland were able to reduce prescription drug use among high utilizers by just 2 percent savings of $1 million 400,000 per year could be achieved. In addition, if the ER and pharmacy costs for the 930 high ER utilizers can be reduced by 10 percent, DHMH could realize savings of approximately $600,000. A two percent reduction in physician and pharmacy costs for those individuals that our analysis suggests an $336,000 savings opportunity. All of these figures would be offset by the cost of staff to manage the program.

Self Audit

While budget constraints have limited many states' abilities to maximize program integrity activities, several (e.g. Texas, Missouri, North Carolina) have initiated self-audit programs that allow providers to voluntarily identify and return overpayments without penalty. According to the DHMH Office of the Inspector General 2008 Annual Report, this strategy was implemented effectively for out-of-state hospitals, resulting on over $600,000 in recoveries in FY 2008. DHMH has recently initiated this strategies for certain instate providers. We suggest the State continue to look for additional self audit opportunities.

Exhibit 13: Projected Resource Requirements to Implement Utilization Review Options

Option	Reg changes	New contracting	Additional staff time (need for re-allocation or new hiring)	Costs	Savings	Net ROI
High cost case review team			✓	Level 1	Level 1	✓
PI-MCPA collaboration			✓	Level 1	Level 1	✓
UR strategic plan			✓	Level 1	Level 1	✓
Hiring more staff			-	Level 2	Level 3	✓
HealthChoice UR – performance measures	✓		✓	Level 1	Level 1	✓
Electronic verification	✓	✓	✓	Level 3	Level 3	✓
Increased use of corrective managed care lock-in	✓		✓	Level 2	Level 2	✓
Self auditing			✓	Level 1	Level 2	✓

All cost projections would require further analysis at DHMH based on more specific implementation plans. Savings are only achievable with the requisite investments indicated above. We categorized costs and savings as Level 1 (<$100k), Level 2 (<$500k), or Level 3 (>$500k). All are expressed as total funds.

6. Conclusions and Implications

The General Assembly required that DHMH and DHR provide "an independent report on claims processing and eligibility payment reduction and utilization review strategies" beyond those already used. In the course of our assessment we found that:

- The DHMH and DHR employ an array of measures to prevent and detect errors and review service utilization and uses techniques that are typical of Medicaid agencies across the nation.
- Maryland's claims error rate and eligibility error rate, calculated through the federal PERM initiative, are both below the national average.
- Multiple opportunities for improving error rates still remain. Claims payment improvements are expected as a result of the planned implementation of a new MMIS. While a CARES replacement or full-scale redesign is not yet underway, national health reform may provide a compelling justification to begin.
- Besides system improvements, there are a number of processes that would require staff time to perform, but would likely result in further reduction in errors. Ideally, system improvements would automate a number of manual processes, freeing staff resources to focus on program monitoring and improvement.
- Our analysis of service utilization identified only small, targeted opportunities for immediate savings, with other opportunities contingent on more research and analysis by DHMH staff. However, there are numerous opportunities to improve internal UR processes, with opportunities for modest (but difficult to quantify) savings.
- In addition to sweeping changes to eligibility and enrollment processes ACA includes a number of provisions designed to enhance Medicaid program integrity efforts nationwide, including expanding contingency-based Recovery Audit Contractor (RAC) vendor contracts.
- Ultimately, to maximize savings, DHMH and DHR will need to allocate greater resources – at all levels of the organization – to reducing errors and managing service utilization.

ACA is expected to significantly increase the number of beneficiaries in the Medicaid program after 2014. While most of the new spending on Medicaid will be through federal dollars, the overall expansion will create new pressures for reducing errors and managing utilization. Investments in the Medicaid infrastructure today will be critical to the Department's ability to manage Medicaid costs in the future.

Appendices

Appendix A: Inventory of Strategies in Existence

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
CLAIMS/PAYMENTS				
MMIS logic edits	Edits are system logic checks aimed at preventing inappropriate payments. Edits control for a wide variety of payment situations drawing upon information from multiple subsystems and claims history files. One edit, for example, verifies that the billing provider is actively enrolled in the program. Another edit checks whether a duplicate of the claim has already been paid. Edits resulting in denied or suspended claims trigger a description of the error to be reported on providers' explanation of benefits (EOB) statements. There are approximately 650 different EOB error descriptions in the MMIS.	Edit programming is throughout the MMIS structure Staff request edits requiring program changes through the customer service request (CSR) process; keyed edits are requested through the policy instruction statement (PIS) process Office of Systems, Operations, and Pharmacy (OSOP) staff programs and deploys edits based on DHMH resources and priorities There is currently a backlog of CSRs awaiting programming	Explanation of benefits error codes and descriptions Requested CSR tracking document	DHMH - MCPA – OSOP
Utilization review criteria	Staff may implement utilization review (UR) criteria in the MMIS UR subsystem. Most established UR criteria fall into several groupings that allow users to deny inappropriate payments: • Procedure lists indicating similar or related codes may be set, for example, such that when one code in the indicated group has paid any subsequent billings will deny. • Contraindications list deny code X if code Y has already paid.	Staff request UR criteria additions and changes through the PIS process OSOP staff enters UR criteria based on DHMH resources and priorities OSOP is up to date with entering requested UR criteria	UR criteria parameter listing	DHMH - MCPA – OSOP

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
	• Limit parameters allow users to designate limits on service units during a specified period of time. Units billed above the limit for the established code will deny.			
MCO Reconciliation • HealthChoice reconciliation • PAC payment adjustments	Review MCO payments to assure payments for the month are appropriate. In HealthChoice, comparisons between MCO enrollment files and MMIS result in MCOs with variance above a threshold into a financial reconciliation. For PAC, DHMH staff reviews known MMIS system payment issues to submit payment adjustments to MCOs.	HealthChoice process is automated PAC payment adjustment is wholly manual; several staff members allocate time each month to conduct review and reconciliation	DHMH provides reports to MCOs detailing results and errors Reconciliation status reports show action taken on claims by MCO as well as amounts paid/recovered	DHMH - MCPA - OSOP
Provider documentation review contract	Through a post-payment hospital bill audit process, the vendor identifies discrepancies and overpayments and ensures reimbursement is based on actual services rendered to patients, provides detailed accounting and verification of findings and recovers monies owed to DHMH based on findings.	Contracted to vendor Health Compliance Associates, LLC Vendor reimbursed on a contingency basis	Vendor provides detailed monthly, quarterly, and annual reports on cases selected, reviewed, and corresponding recovery activities Collections reported on collection cost avoidance reports	DHMH - MCPA - OHS
Electronic claiming	DHMH receives over 90 percent of claims for reimbursement electronically. To facilitate additional electronic submission, DHMH developed an eClaim provider portal to provide an electronic billing avenue, especially for smaller providers. The eClaim portal is not widely used. • Claims not received electronically are manually keyed by State and contractual staff. A majority of paper claims (nearly 60 percent) are for crossovers. OSOP staff anticipate that recent policy changes will	Approximately 30 staff members are dedicated to keying paper claims	Several OSOP reports, including the Weekly Incoming Claim Document Count report, provide counts of paper claims by type	DHMH - MCPA - OSOP

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
	significantly reduce the number of paper crossover claims. • For approximately 15 percent of paper claims, DHMH requires the provider to submit on paper due to required attachments. OSOP is investigating opportunities to accept data electronically to reduce required paper attachments.			
Report monitoring	Office of Finance (OF) staff request a variety of reports from MMIS. OF staff routinely monitors the reports and identifies and assesses program payment variations (such as payment spikes). Staff in other program areas may also request one-time or routine reporting; however, limited use of MMIS-generated reports for program monitoring was identified.	Staff can request one-time or regularly produced reports through CSRs OSOP program and provide reports to staff	List of MMIS reports	DHMH - MCPA – OSOP
Claims preprocessing	Prior to MMIS adjudication, DHMH routes claims through a preprocessor. The preprocessor reviews claims for HIPAA compliance and either "translates" claims into a format compatible with the MMIS or rejects claims that do not meet DHMH's criteria for an acceptable claim submission.	OSOP and contract staff maintain translator		DHMH - MCPA – OSOP
Provider Training	Most provider training occurs through transmittals, billing instructions, and memos on EOB statements and is generally targeted to policy changes, the introduction of new programs, and altered reimbursement policy. DHMH staff conducts some targeted trainings for providers with limited billing experience. Due to limited staff resources and lack of provider interest, provider field training is very limited.	OHS – program staff engage in provider training as needed OSOP - 1 to 2 staff members		DHMH - MCPA – OSOP and OHS
Nursing facility and	Nurses review every Medicaid nursing facility	Contracted utilization	Utilization control	DHMH - MCPA –

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
chronic hospital onsite record review	and chronic hospital resident record to verify payment level	control agent function	agent monthly and annual reports by institutional and community based service	OHS
Provider credentialing and enrollment	Provider credentialing and enrollment aim to ensure that only appropriately qualified providers enroll in Medicaid. When a provider submits an application to enroll, provider enrollment conducts a review of the State and federal fraudulent provider listings and also reviews for required licensure. DHMH requires provider credentialing review for provider types with more specialized requirements (e.g., licensure, training, back ground checks).	When applicable, staff in the OHS credentials providers OSOP staff is responsible for provider application review, application approval, and entering provider and provider information into MMIS		DHMH - MCPA – OSOP and OHS
Preauthorization Of major services include: - Inpatient hospital - Private duty nursing - Durable medical equipment - HCBS waiver services - Pharmacy - Long-term care - Mental health - Dental	- Inpatient Hospital (3808 process for preauthorization) - Private Duty Nursing (Every case is preauthorized) - Durable Medical Equipment (Preauthorization required for high cost services) - HCBS Waiver Services (All beneficiaries require plans of care) - Pharmacy (ACS conducts preauthorization program using SmartPA. Also prescription drug list, quantity limits and dose optimization) - Long-Term Care (Level of care determination process) - Mental Health (Vendor reviews claims and preauthorizes services) - Dental (Preauthorization is required for specific services (e.g., dentures,	Mostly functions within OHS or contracted (pharmacy contracted to ACS, dental contracted to DentaQuest) Waiver service plans of care developed by administering agencies	Contracts with vendors	DHMH - MCPA - OHS, and other agencies (with OHS oversight) DHMH - MCPA – OSOP oversees pharmacy

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
	orthodontics)) - Some special services such as transplants also require preauthorization			
Coordination of benefits - Third party liability	Vendor makes 600-900 referrals to DHMH for individuals who likely have private coverage. State staff follow-up on referrals and enter appropriate TPL information into MMIS. MMIS edits against the TPL files when adjudicating claims.	Contracted vendor, HMS Approximately 12 DHMH staff	Cost avoidance statistics reported quarterly	DHMH - MCPA – OSOP
HCBS waiver billing systems	Administering agency staff enters claims for most waiver services into stand alone billing system prior to submission to MMIS for reimbursement. The stand alone billing systems verify that the services and units claimed are within each beneficiary's plan of care.	Administering agency staff either perform or contract billing services functions		Departments or agencies administering HCBS waivers
NCCI edits	Patient Protection and Affordable Care Act requires that each state Medicaid program implement compatible methodologies of the National Correct Coding Initiative to promote correct coding and to control improper coding leading to inappropriate payment on all claims paid on or after October 1, 2010. DHMH contracted with the provider documentation review contractor to apply the NCCI editing to Maryland's paid professional claims.	Contracted to vendor Health Compliance Associates, LLC Vendor reimbursed on a contingency basis		DHMH – MCPA - OHS
PERM and PERM corrective action plan (CAP)	PERM is a federally-mandated review of Medicaid and CHIP claims and eligibility. For the claims reviews component of the program, federal contractors select and review a random sample of FFS claims and managed care payments. CMS uses findings from the review to calculate an annual payment error rate for the state's Medicaid program. In the required PERM CAP, states analyze errors; develop,	OF coordinates overall DHMH PERM efforts OHS staff monitor data processing reviews	PERM error rate, CAP report	DHMH – MCPA – OF and OHS

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
	implement, and monitor corrective actions; and evaluate the effectiveness of the actions.			
		ELIGIBILITY		
CARES-MMIS interface edits	CARES and MMIS interface in a nightly process in which CARES updates MMIS eligibility subsystem records. MMIS reviews incoming CARES information against approximately 80 MMIS system logic edits to ensure quality data transmission. Edits range from inappropriate non-numeric submissions and invalid or missing identification numbers to gender/coverage mismatches. Information triggering an edit produces a certification turnaround document (CTAD) Office of Eligibility (OE) staff manually review for reconciliation. Staff reconciles approximately 2,400 CTADs each week. DHMH adds CARES-MMIS interface editing to account for areas in which CARES has not been updated (e.g., coverage category no longer active; however, CARES continues to allow case workers to post eligibility on that category).	Manual CTAD review performed by 12 staff members (staff also perform other manual eligibility functions such as enrollment of coverage groups not in CARES)	OE production reports	DHMH - MCPA – OE
Automated supervisory review system	DHR supervisors conduct three Medicaid reviews per case manager per month (unless the office has received a wavier).	All DHR eligibility supervisors	Between February 2010 and July 2010, supervisors reviewed 22,495 cases	DHR
Case Worker Training	OE staff engages in training of Medicaid eligibility workers through written communications and in-person course training • Written training, typically initiated by policy changes or errors indicating a need for clarification, includes action transmittals and CARES bulletins with CARES instructions	1 supervisor (position vacant) and 4 trainers		DHMH - MCPA – OE

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
	• OE staff trains new eligibility case workers that DHR and the LHDs send to Medicaid training; also conduct targeted additional trainings			
MEQC	MEQC is a federally required program. Maryland conducts MEQC as a pilot, meaning that DHMH focuses on a particular population subset for review during the year. Error rate reflects on errors within the reviewed sample. The MEQC unit produces an annual report with findings.	1 supervisor and 6 staff	Annual reports with error findings	DHMH – MCPA - OE
PERM and PERM corrective action plan (CAP)	PERM is a federally-mandated review of Medicaid and CHIP claims and eligibility. For eligibility reviews component of the program, states select and review a random sample of active and negative cases. CMS uses the findings from the review to calculate an annual payment error rate for the state's Medicaid program. In the required PERM CAP, states analyze errors; develop, implement, and monitor corrective actions; and evaluate the effectiveness of the actions.	PERM eligibility reviews conducted by contractual staff All error findings re-reviewed by OE staff	PERM error rate, CAP report	DHMH - OIG; DHMH – MCPA – OE
UTILIZATION REVIEW				
Program Integrity Division	Addresses potential and actual fraud and abuse of DHMH programs by external providers and recipients including through use of the Surveillance and Utilization Review Subsystem (SURS) to analyze Medicaid claims data	32 staff – 24 work primarily in provider reviews, 8 in recipient reviews and special projects; positions available for 4.5 nurses and 1 pharmacist	Reports include financial summaries, recovery postings, data support task summaries, and case reports	DHMH - OIG - Division of Program Integrity
Utilization control contract	Utilization control activities for hospitals and nursing facilities, and front-end eligibility assessments for HCBS programs. Most activities are pre-payment, but UR functions in the contract include retrospective reviews of	Contracted to vendor	Monthly contractor reports summarize review activity. Annual contractor reports include goals,	DHMH – MCPA – OHS

Topic Area	Strategy Description	Dedicated Resources/Oversight	Information/Output/ Reports Available	Organizational Placement
	hospital services and nursing facility billing practices. 3808 post-authorization process is to review medical necessity and days approved.		progress, and methods for identifying and reporting abuses of utilization and payment.	
Pharmacy prospective utilization review	Prospective Drug Utilization Review program is conducted by a contractor. The contractor's automated processing system applies numerous edits to all eligible claims. Edits include but are not limited to the therapeutic duplications, drug-drug interactions, quantity limitation, step therapy, clinical criteria, and early refill for therapeutic and clinical appropriateness, age, sex, and diagnosis (when available).	Pro-DUR vendor is ACS Healthcare, LLC	Monthly contractor reports summarize review activities for improved clinical and financial outcomes	DHMH – MCPA – OSOP - Pharmacy
Pharmacy retrospective utilization review	Retrospective Drug Utilization Review program is conducted by a contractor. DHMH staff also conduct reviews of high cost claims, identify system problems, and assist the OIG. Corrective managed care program requires recipients to use a specific pharmacy (no one is currently enrolled).	DUR vendor is Health Information Designs 1 part time DHMH pharmacist also conducts retrospective reviews		DHMH – MCPA – OSOP
Additional program-specific and budget report monitoring	DHMH staff review quarterly program-specific reports including findings such as "Date of Death" and "NF-DME Claim Overlap." Also run ad hoc queries when problems are suspected. As part of the routine budget monitoring process, MCPA budget staff produces a monthly report (the "Stat Pack") that tracks the units of service billed each month in major program categories. When spikes become apparent, budget staff checks with program staff for potential explanations.	Staff can request one-time or regularly produced reports through CSRs OSOP program and provide reports to staff		DHMH - MCPA

Appendix B: Elderly Medicaid Beneficiaries without Medicare Coverage

Exhibit B-1 is an analysis comparing Maryland to nearby states and the District of Columbia. The table shows that Maryland has the highest share of elderly Medicaid beneficiaries without Medicare coverage of states in the Mid-Atlantic region, and has a much higher share of elderly Medicaid beneficiaries without Medicare coverage (11.1 percent) than the entire region (6.1 percent).

Exhibit B-1: Share of Medicaid Enrollees Age 65 or Older without Medicare – Mid Atlantic Region Comparison

	Total Number of Medicaid Enrollees Age 65 or Older	Total Number of Medicaid Enrollees Age 65 or Older without Medicare	Share of Medicaid Enrollees Age 65 or Older without Medicare
Delaware	14,078	863	**6.1%**
District of Columbia	14,955	1,499	**10.0%**
New Jersey	147,890	11,737	**7.9%**
Pennsylvania	235,690	14,422	**6.1%**
Virginia	104,334	5,032	**4.8%**
West Virginia	41,171	385	**0.9%**
Mid-Atlantic Region Total	558,118	33,938	**6.1%**
Maryland	73,139	8,125	**11.1%**

Source: 2008 Monthly State Summary, Medicaid Statistical Information System (MSIS) State Summary Datamart

Finally, ***Exhibit B-2*** compares the share of elderly Medicaid beneficiaries without Medicare coverage between Maryland and the Northeast Region. There are two states in the Northeast Region (Massachusetts and Ohio) that have a higher share of elderly Medicaid beneficiaries without Medicare coverage, and Maryland's share is only slightly higher than New York's share of elderly Medicaid beneficiaries without Medicare. However, Maryland's share of elderly Medicaid beneficiaries without Medicare coverage (11.1 percent) is still higher than the Northeast Region share of 9.5 percent.

Exhibit B-2: Share of Medicaid Enrollees Age 65 or Older without Medicare - Northeast Region Comparison

	Total Number of Medicaid Enrollees Age 65 or Older	Total Number of Medicaid Enrollees Age 65 or Older without Medicare	Share of Medicaid Enrollees Age 65 or Older without Medicare
Connecticut	67,397	4,084	**6.1%**
Delaware	14,078	863	**6.1%**
District of Columbia	14,955	1,499	**10.0%**
Massachusetts	162,557	25,121	**15.5%**

	Total Number of Medicaid Enrollees Age 65 or Older	Total Number of Medicaid Enrollees Age 65 or Older without Medicare	Share of Medicaid Enrollees Age 65 or Older without Medicare
Maine	57,540	1,177	**2.0%**
New Hampshire	15,008	886	**5.9%**
New Jersey	147,890	11,737	**7.9%**
New York	566,914	59,168	**10.4%**
Ohio	180,089	21,849	**12.1%**
Pennsylvania	235,690	14,422	**6.1%**
Rhode Island	24,577	1,295	**5.3%**
Vermont	20,088	773	**3.8%**
Northeast Region Total	1,506,783	142,874	**9.5%**
Maryland	73,139	8,125	**11.1%**

Source: 2008 Monthly State Summary, Medicaid Statistical Information System (MSIS) State Summary Datamart

Appendix C: Prescription Drug Utilization

In FY 2009, 202,950 Medicaid beneficiaries filled a prescription that was paid FFS by Maryland Medicaid. While the majority of those individuals filled between one and five prescriptions during the year, approximately 10 percent filled 33 or more. The top five percent of users filled 49 or more, and the top one percent filled 111 or more. For all users combined, the total number of prescriptions filled was 2,646,169, an average of about 13 prescriptions per member. Total FFS costs for prescriptions was $305.6 million, an average of $1,506 per member that received a prescription.

To evaluate the potential to reduce FFS prescription costs we identified a cohort of 5,065 "high utilizers" that had 72 or more prescriptions filled during the year. These members received a total of 600,902 prescriptions totaling $56.4 million, an average of $11,135 per member. Prescriptions for depression, anxiety and pain medications accounted for 16.57 percent of the prescriptions utilized by these high utilizers. To explore whether these individuals might be abusing prescription medications, we evaluated the therapeutic classes utilized by members receiving depression, anxiety and pain medication. The top five therapeutic classes for drug utilized by these members are in ***Exhibit C-1***.

Exhibit C-1: Top Five Therapeutic Classes

Therapeutic Class	Prescriptions
Antipsychotic Agents	61,120
Antidepressants	45,183
Miscellaneous Anticonvulsants	41,833
Opiate Agonists	33,379
Beta-Adrenergic Blocking Agents	17,689

To further explore the potential for abuse, we looked at the number of physicians that prescribed medications for these high utilizers. Members that had prescriptions ordered by one or two physicians accounted for 38 percent of the members and 18 percent of the members had 6 or more prescribing physicians.[27] The number of prescriptions ordered for high utilizers by therapeutic class was also examined to see if there was any evidence of excessive utilization. The therapeutic classes with the highest maximum number of prescriptions ordered are in ***Exhibit C-2***.

Exhibit C-2: Highest Maximum Number of Prescriptions

Therapeutic Class	Total Prescriptions	Mean Prescriptions	Maximum Prescriptions
Antimanic Agents	14,843	41.7	248
Antipsychotic Agents	48,555	23.1	233
Multivitamin Preps	3,111	21.8	221

[27] The analysis only counted numbers of different prescribing physicians. We did account for prescribing physicians located within one practice.

Other Misc. Therap.	6,974	29.7	215
Loop Diuretics	25,150	29.2	212
Antidepressants	32,133	17.1	210
Thiazide Diuretics	12,594	32.2	207
Opiate Agonists	32,238	14.7	162

Appendix D: Emergency Room Utilization

In FY 2009, 71,651 beneficiaries of Maryland's FFS Medicaid program visited a hospital emergency room (ER) a total of 133,054 times, and DHMH paid $51.7 million for ER services at an average of $722 per person that visited an ER. While the majority of those individuals only visited the ER once or twice, approximately 10 percent of users visited the ER multiple times. The top five percent of users made five or more visits and the top one percent made eleven or more visits.

To evaluate the potential to reduce ER utilization we evaluated the utilization characteristics of 930 members identified as "high utilizers" who visited the ER 10 or more times during the year. These members represent approximately 1.3 percent of ER users, but account for 12.5 percent of total ER visits and approximately 10 percent of ER reimbursements (see ***Exhibit D-1***).

Exhibit D-1: ER Visits and Reimbursements for High ER Utilizers

High Utilizers	Total High Utilizers	Average High Utilizers	Percent of Total
ER Visits	16,684	17.9	12.5 %
ER Reimbursement Amount	$5,104,296	$5,488	9.9 %

Almost half of the primary diagnoses recorded on ER visits for high utilizers were for lower acuity conditions. The primary diagnoses treated were low acuity skeletal, gastro-intestinal, pulmonary, and skin conditions. To gain further insight into the medical conditions of these "high utilizers" we also evaluated their pharmacy utilization. Of the 930 high utilizers, 517 had at least one FFS pharmacy claim. These 517 beneficiaries received 14,603 prescriptions – an average of 28.2 prescriptions each – for a total cost of over $1 million, or $2,000 per member. Just under 40 percent of the prescriptions filled by these members were for pain, anxiety, and depression medications. The top five therapeutic classes for drugs utilized by these members are in ***Exhibit D-2***.

Exhibit D-2: Top Five Therapeutic Classes for High ER Utilizers

Therapeutic Class	Prescriptions
Opiate Agonists	1,912
Benzodiazepines (Anxiolytic,Sedativ/Hyp)	1,776
Antipsychotic Agents	1,253
Antidepressants	1,219
Benzodiazepines (Anticonvulsants)	896

This combination of lower acuity medical conditions and large utilization of pain, anxiety, and depression medications left open the possibility that some of these members may be obtaining prescription medications that are not medically necessary. Forty percent of these members went to one or two ERs, while 18 percent of the members visited five or more.

Appendix E: Physician Office Visit Utilization

Analysis of Physician Office Visit Utilization

In FY 2009, 157,418 members of Maryland's FFS Medicaid program visited a physician. While the majority of those individuals had between one and three physician visits in the year, approximately five percent of users visited a physician 16 or more times. The top one percent of users made 28 or more visits. The total number of visits for all users combined was 766,180. Maryland paid $42,489,247.50 in physician reimbursements. Five percent of the members used in excess of $870 worth of office visits.

To evaluate the utilization habits of high utilizers of physician services we examined members with 16 or more physician visits. This cohort included 8,506 members and accounted for 22 percent of physician visits and over $9.3 million in expenditures, 25 percent of physician spending. The most common primary diagnoses reported for this cohort were for skeletal, cardiovascular, psychiatric and pulmonary disorders. Approximately 29 percent of the primary diagnoses treated represented lower acuity conditions, the remaining 71 percent were for medium to very high acuity conditions. The disease conditions for physician high utilizers were for higher acuity conditions than the diagnoses reported for high utilizers of ER services.

Of the high physician utilizers, 3,836 beneficiaries had at least one prescription paid by Medicaid FFS. Among these 3,836 beneficiaries Medicaid FFS paid for 87,109 prescriptions totaling $7.5 million, an average of 23 prescriptions, $1,947 per member. The most common prescriptions were to treat depression, anxiety, cardiac conditions, asthma, and pain disorders. To determine if any of these members appeared to be misusing prescriptions we focused on 2,517 members receiving prescriptions to treat depression, anxiety, and pain. These members used $5.2 million worth of prescription drugs, in excess of 55 percent of the drug expenditures for the high utilizers cohort.

The top five therapeutic classes for prescriptions for members evaluated in this group are in ***Exhibit E-1***.

Exhibit E-1: Top Five Therapeutic Classes for High Physician Visit Utilizers

Therapeutic Class	Prescriptions
Benzodiazepines (Anxiolytic,Sedativ/Hyp)	9,943
Antidepressants	5,913
Opiate Agonists	5,021
Benzodiazepines (Anticonvulsants)	3,656
Antipsychotic Agents	2,491

Fifteen percent of the high utilizer group was treated by one or two physicians in their office, 40 percent of these members saw five or more physicians. The primary diagnoses reported on the physician office visits for potential shopping members were classified as low acuity for 33 percent of the members; the remaining 67 percent were treated for medium to high acuity medical conditions.

Independent Report on Medicaid Cost Savings: Payment Errors, Eligibility Errors, and Utilization Review

Option	Lewin Recommendation	DHMH/DHR Response
Exhibit 5: Page 18		
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.
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.
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.

Option	Lewin Recommendation	DHMH/DHR Response
Exhibit 9: Page 29		
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. The 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.
Training Enhancements	Enhanced equipment and software could provide on line 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.

Option	Lewin Recommendation	DHMH/DHR Response
DHR staffing and 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 request.	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.
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.

Option	Lewin Recommendation	DHMH/DHR Response
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.
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.
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.

Option	Lewin Recommendation	DHMH/DHR Response
Exhibit:13 Page 39		
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.
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.
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 FY 2012.
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. The Department would also benefit from additional clinical staff, beyond the current 4.5 nurses and one pharmacist that are 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 required clinical assessments, which will result in more recoveries. DHMH will analyze and determine the staffing costs associated with these additional reviews.

Option	Lewin Recommendation	DHMH/DHR Response
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.
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.
Increased Use of Corrective Managed Care Lock-In Program	Review opportunities to lock-in MCO patients to one predetermined 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.

Option	Lewin Recommendation	DHMH/DHR Response
Self Auditing	Several states(e.g. Texas, Missouri, 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 FY 2008. DHMH has recently initiated this strategy for certain instate 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.