HB 1329

Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE

House Bill 1329 (Delegate Hixson, *et al.*)
Health and Government Operations

Medical Assistance Programs - Fraud and Abuse Prevention

This bill requires the Department of Health and Mental Hygiene (DHMH) to implement a prepayment provider verification and screening system and a prepayment predictive modeling and analytics system for Medicaid and the Maryland Children's Health Program (MCHP).

Fiscal Summary

State Effect: Despite the bill's stated intent to fund the new requirements with savings achieved by the bill, there will be implementation costs. Medicaid expenditures increase by a total of $2.8 million in FY 2014 ($759,600 in general funds) for one-time computer reprogramming expenses and ongoing personnel expenditures. Future years reflect annualization and inflation. To the extent that the bill prevents payment of ineligible claims, Medicaid expenditures (50% general funds, 50% federal funds) could be reduced. The amount of any savings cannot be reliably estimated but would likely be sufficient to pay for administrative costs in FY 2015 and future years.

(in dollars)	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
FF Revenue	$2,009,600	$168,100	$176,100	$184,500	$193,400
GF Expenditure	$759,600	$168,100	$176,100	$184,500	$193,400
FF Expenditure	$2,009,600	$168,100	$176,100	$184,500	$193,400
Net Effect	($759,600)	($168,100)	($176,100)	($184,500)	($193,400)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Prepayment Provider Verification and Screening System: This system must check billing and provider data against a provider database, prevent payment from being made to ineligible health care providers, and prevent payment from being sent to an incorrect address.

Prepayment Predictive Modeling and Analytics System: This system must be integrated into the Medicaid claims workflow and include all Medicaid providers, recipients, and geographic areas served. Before any payment is made, this system must analyze billing and utilization patterns and identify patterns that exhibit a high risk of fraudulent activity; prioritize claims for additional review based on the likelihood of potential waste, fraud, or abuse; and prevent payment from being made until such claims have been validated. DHMH must use information from adjudicated Medicaid and MCHP claims to refine and enhance the system.

Uncodified Language: Uncodified language expresses legislative intent that (1) the State must contract for the services necessary to implement the bill; (2) the savings achieved through implementation of the bill must cover the costs of the services; (3) services may be secured using a variety of models in which the State's only direct costs will be funded through the actual savings achieved; and (4) a model may include performance guarantees of the contractor to ensure that identified savings exceed costs.

Current Law: As Medicaid program administrators, states are required under federal regulations to implement certain measures and procedures aimed at preventing fraud and abuse, including (1) verification of the eligibility of providers to participate in federal health care programs; (2) procedures to verify that recipients actually received billed services; (3) procedures to identify suspected fraud cases; and (4) methods for investigating fraud cases, including procedures for referring suspected fraud cases to law enforcement officials and state Medicaid fraud control units.

The Medicaid Fraud Control Unit investigates and prosecutes provider fraud in state Medicaid programs. In addition to any other penalties provided by law, a health care provider that violates a provision of the Medicaid fraud part of the Criminal Law Article is liable to the State for a civil penalty of not more than triple the amount of the overpayment. If the value of the money, goods, or services involved is $500 or more in the aggregate, a person is guilty of a felony and on conviction is subject to imprisonment for up to five years and/or a fine of up to $100,000.

A person who violates the Maryland False Claims Act is liable to the State for a civil penalty of up to $10,000 and up to triple the State's damages resulting from the violation. However, the total amount of a violator's liability to the State may not be less than the amount of the actual damages the State health plan or State health program incurred as a result of the false claims violation.

Background: In a program as large as Medicaid, even small efforts to improve program integrity (preventing errors in payment and eligibility, as well as service utilization review) can yield substantial savings. A greater emphasis on program integrity is one focus of the federal Patient Protection and Affordable Care Act (ACA), and recent State audits of Medicaid have focused on the same issue.

An independent review of current Medicaid program integrity efforts detailed a significant level of activity but also numerous additional strategies to reduce claims and eligibility errors. A 2011 *Joint Chairmen's Report* (JCR) updated the implementation status of some of these strategies. For claims processing, the replacement of the legacy Medicaid Management Information System (MMIS) was identified as the most important long-term solution and that process is underway. In terms of improving eligibility, the primary strategy recommended is upgrading technology, specifically through improving/replacing the Department of Human Resources' Client Automated Resource and Eligibility System (CARES). Development of the Maryland Health Benefit Exchange Eligibility System is now underway, beginning what could eventually be a replacement system for CARES. A number of the other recommendations made by the independent review were reflected in DHMH's cost-containment strategy for fiscal 2013, including ensuring that, to the maximum extent possible, health service costs are charged to Medicare for cross-over claims, maximizing Medicare enrollment, and implementing an electronic verification system for Medicaid in-home services.

According to a 2009 Lewin Group report, prepayment systems offer the advantage that improper payments are prevented from ever being made. Historically, prepayment screening methods have seen limited application due to a large number of "false positives." Experience in the commercial sector indicates that predictive models have largely mitigated these problems through improved methods, with applications in the commercial sector achieving accuracy rates in excess of 80%.

In June 2011, the federal Centers for Medicare and Medicaid Services (CMS) implemented the Fraud Prevention System (FPS), a predictive analytics system that analyzes all Medicare fee-for-service claims to detect potentially fraudulent activity. FPS uses algorithms and models to examine Medicare claims in real time to flag suspicious billing. As each claim goes through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns. Analysts then review prioritized cases

by reviewing claims histories, conducting interviews, and performing site visits. If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. In the first year of implementation of FPS, CMS found that the system "prevented or identified an estimated $115.4 million in payments," including $31.8 million in actual savings and $83.6 million in projected savings. FPS also generated 536 leads for investigation by CMS's program integrity contractors and augmented information for 511 preexisting investigations.

State Expenditures: Although the bill states that it is the intent of the General Assembly that the savings achieved through the bill cover the costs of implementation, DHMH indicates that there will be upfront costs to implement the bill. Furthermore, DHMH advises that Maryland's Medicaid payment error rate measurement is one of the lowest in the country; therefore, any anticipated savings are likely to be minimal.

To implement the requirements of the bill, Medicaid expenditures increase by a total of $2.8 million in fiscal 2014, which reflects the bill's October 1, 2013 effective date. This estimate reflects the cost of significant reprogramming of the MMIS computer system and hiring six provider relations and claims processing staff to respond to provider inquiries, complaints, and claims adjustments that will arise under the new systems. The estimate includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. Reprogramming expenditures are higher than estimated in previous years as both the existing MMIS and the new MMIS system will need to be modified. DHMH is in the process of making substantial eligibility and claims payment program changes and does not have the resources to devote to this project. MMIS expenses are eligible for a 75% federal matching rate, while personnel expenses will receive a 50% matching rate.

	FY 2014	FY 2015
Positions	6	
MMIS Computer System Changes	$2,500,000	$0
Salary and Fringe Benefits	238,889	332,644
One-time Start-up Costs	27,690	0
Other Operating Expenses	2,588	3,485
Total Administrative Expenditures	**$2,769,167**	**$336,129**

Future years reflect full salaries with increases and employee turnover as well as annual increases in operating expenses.

To the extent that implementation of a prepayment provider verification and screening system and/or a prepayment predictive modeling and analytics system reduces Medicaid payment of ineligible claims, Medicaid expenditures (50% general funds, 50% federal funds) could be reduced.

Additional Information

Prior Introductions: A substantially similar bill, HB 792 of 2012, was heard by the House Health and Government Operations Committee, but it was later withdrawn.

Cross File: None.

Information Source(s): *Report to Congress: Fraud Prevention System First Implementation Year,* Centers for Medicare and Medicaid Services, December 2012; *Comprehensive Application of Predictive Modeling to Reduce Overpayments in Medicare and Medicaid*, The Lewin Group, Inc., 2009; Centers for Medicare and Medicaid Services; Department of Health and Mental Hygiene; Department of Legislative Services

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