HB 792

Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

House Bill 792 (Delegate Ready, *et al.*)
Health and Government Operations

Health - 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, a prepayment predictive modeling and analytics system, and a prepayment fraud investigative service for Medicaid and the Maryland Children's Health Program (MCHP). Uncodified language states that it is the intent of the General Assembly that the savings achieved through the bill must cover the costs of implementation and that the services used in implementing the bill must be secured using a shared savings model in which the State's only direct cost will be a percentage of actual savings achieved.

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 $1.3 million in FY 2013 ($379,500 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 for 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 2014 and future years.

(in dollars)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
FF Revenue	$879,500	$157,200	$167,800	$175,900	$184,300
GF Expenditure	$379,500	$157,200	$167,800	$175,900	$184,300
FF Expenditure	$879,500	$157,200	$167,800	$175,900	$184,300
Net Effect	($379,500)	($157,200)	($167,800)	($175,900)	($184,300)

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 analyze billing and utilization patterns and identify patterns that exhibit a high risk of fraudulent activity; analyze and score claims based on the likelihood of potential waste, fraud, or abuse; select claims for additional review that receive a high score for potential waste, fraud, and abuse; and prevent payment from being made until such claims have been validated. DHMH must use information from adjudicated claims to refine and enhance the system.

Prepayment Fraud Investigative Service: This service must combine retrospective claims analysis and prospective waste, fraud, or abuse detection techniques. The service must include analysis of specified information and direct patient and provider interviews. The service must also provide education to providers and give providers an opportunity to review and correct any problems identified before a claim is adjudicated.

If DHMH contracts with an entity to implement the bill's provisions, it must allow the entity to access any information or data required to carry out the contract and take any action necessary to facilitate public-private data sharing.

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 MMIS system was identified as the most important long-term solution and that process in 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 form part of DHMH's cost-containment strategy for the fiscal 2013 budget, 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." Recent 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 a predictive analytics system that will analyze all Medicare fee-for-service

claims to detect potentially fraudulent activity. The predictive analytics system 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.

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 Medicaid's payment error rate measurement (PERM) 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 $1.3 million in fiscal 2013, which reflects the bill's October 1, 2012 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. MMIS expenses are eligible for a 75% federal matching rate, while personnel expenses will receive a 50% matching rate.

	FY 2013	**FY 2014**
Positions	6	
MMIS Computer System Changes	$1,000,000	$0
Salary and Fringe Benefits	229,523	311,086
One-time Start-up Costs	26,910	0
Other Operating Expenses	2,475	3,333
Total Administrative Expenditures	**$1,258,908**	**$314,419**

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, a prepayment predictive modeling and analytics system, and a prepayment fraud investigative service reduce Medicaid payment of ineligible claims, Medicaid expenditures (50% general funds, 50% federal funds) could be reduced.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): *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 Budget and Management; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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