GOVERNOR'S OFFICE OF BUDGET AND PROGRAM PLANNING

Fiscal Note 2015 Biennium

Bill #	HB0171	**Title:**	Revise laws related to medicaid and children's health program fraud
Primary Sponsor:	Smith, Cary	**Status:**	As Introduced

- ☐ Significant Local Gov Impact
- ☑ Needs to be included in HB 2
- ☑ Technical Concerns
- ☐ Included in the Executive Budget
- ☐ Significant Long-Term Impacts
- ☐ Dedicated Revenue Form Attached

FISCAL SUMMARY

	FY 2014 Difference	FY 2015 Difference	FY 2016 Difference	FY 2017 Difference
Expenditures:				
General Fund	$203,125	$0	$0	$0
Federal Special Revenue	$203,125	$0	$0	$0
Revenue:				
General Fund	$0	$0	$0	$0
Federal Special Revenue	$203,125	$0	$0	$0
Net Impact-General Fund Balance:	($203,125)	$0	$0	$0

Description of fiscal impact: Technology tools for predictive modeling and analytics to assist the state in the detection of fraud, waste, abuse and overpayment of Medicaid claims currently exist for Medicaid claims but not for Developmental Disability (DD) claims. These tools will be available for Medicaid and DD under the new Health Enterprise scheduled for implementation in the spring of 2015.

FISCAL ANALYSIS

Assumptions:

1. The Department of Public Health and Human Services (DPHHS) utilizes a comprehensive database for the processing of Medicaid health care claims via contracted services for the state's Medicaid Management Information System (MMIS). The current legacy system is over 30 years old.
2. The department utilizes other information technology solutions for the processing of developmental disability (DD) prior authorization, post review, and claims processing and payments. These systems, known as Agency Wide Accounting Client System (AWACS-DD and AWACS-CSS), are legacy systems that are over 15 years old.
3. The department is also under contract to design and develop a new MMIS for Montana. The new system, Health Enterprise, will contain many of the features and functions identified in this bill. Health Enterprise

will incorporate the preauthorization, post review and claims processing, and payment functionalities of both the legacy MMIS and DD systems.

4. Health Enterprise is scheduled for implementation in the spring of FY 2015.
5. The table below includes several of the business requirements of the Health Enterprise request for proposal (RFP) that support the details of HB 171:

SAR#14	Provide functionality to interface with multiple entities outside of the MMIS for exchange of information such as eligibility determination systems, prior authorization entities, and immunization and Death Registries.
DS#8	Incorporate a highly adaptable fraud and abuse detection subsystem and SURS component for the ongoing, retrospective, comprehensive analysis of MMIS data for the detection of potential provider and client fraud, abuse, or aberrant utilization of the Montana Health Care Program.
DS#29	Support a range of analysis actions and supply appropriate predictive modeling tools, including but not limited to: a. Benefit modeling b. Utilization management c. Care management profiling d. Program planning, forecasting e. Program assessment f. Provider or contractor performance g. Quality assurance h. Fraud detection i. Comparison of fee-for-service and PCCM care j. Other functions as defined by the state.
DS#47	Include all Fraud Detection functions as detailed in the Program Integrity section.
PI#3	Produce Provider profiling and Fraud and Abuse Detection reports including but not limited to: a. Rendering provider; b. Pay-to provider; c. Referring provider; d. Primary care Provider; e. Group provider number; f. National Provider Identifier (NPI); g. Prescribing provider; and h. Billing services or other non-traditional providers
PI#42	Support pattern recognition and provide an automated fraud and abuse profiling system for the ongoing monitoring of provider and client claims to detect patterns of potential fraud, abuse and excessive billing.
PI#49	Perform detection of potential fraud or abuse by: a. Providing a proven statistical methodology to classify clients into peer groups using user-defined criteria such as age, sex, race, ethnicity, living arrangement, geographic region, program, aid category, and special program indicator (or any combination thereof) for purposes of developing statistical profiles b. Providing a proven statistical methodology to classify private/public providers into peer groups using user defined criteria such as program, category of service, provider type, multiple specialties, multiple sub-specialties, type of practice/organization,

	enrollment status, facility type, geographic location, billing versus performing providers, and size or any combinations thereof, for the purpose of developing statistical profiles c. Providing a proven statistical methodology to classify and reclassify treatment into user defined groups, by diagnosis code, drug code, procedure code, episode of care, groups or ranges of codes, geographical region, or combination thereof, for the purpose of developing statistical profiles d. Generating random sampling using a State-approved methodology, including stratified random sampling, with associated statistics (for example: universe statistics and confidence levels) Document the random sampling methodology for use in court hearings. Provide the option to preserve the random seed to reproduce the random sample or to generate a new seed to produce a new random sample e. Generating statistical norms and statistical samples, by peer or treatment group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles f. Extrapolating sample results using generally accepted statistical techniques; this capability must include the ability to extrapolate, at various levels of confidence, instances of attributes or occurrences in the sample (number of claims with errors) and value of variables in the sample (dollar overpayments) g. Comparing claims to parameters approved by the State.

6. The functionality identified in the above listed requirements meets the requirements of the bill by utilizing the predictive modeling and analytics technology that is integrated in the system for processing and payment of healthcare claims for Medicaid and Healthy Montana Kids (HMK).

Medicaid

7. Following are several of the capabilities and functionalities contained in the current MMIS that meet the requirements of the bill. The current MMIS:
    a. Contains numerous edits to validate healthcare claims before payment is made and has the capability to suspend payment for review before payment is made.
    b. Provider payments can be suspended for credible allegations of fraud, to prevent inappropriate payment from occurring while the provider is being investigated.
    c. Performs real-time pre-adjudication claims editing based on national payment standards for accredited industry sources, transparency for all participants in the claims cycle, business intelligence, and increased auto-adjudication and processing efficiencies. These functions also identify aberrant behaviors in terms of procedures, frequency of patient visits, place of service and other pertinent data.
8. New section three of the bill requires the department to implement a program to review and verify information and claims submitted by providers against a database of provider information in order to automate reviews and identify and prevent inappropriate payments and references providers who have been sanctioned by a professional licensing board.
9. The requirements of new section three of the bill are currently being met through the functionality of the MMIS and through various degrees of sanctions related to licensure of professionals by the Department of Labor and Industries medical professional licensing boards.
10. Additionally the Surveillance, Utilization and Review System unit of the department's Quality Assurance Division conducts audits of this same information and works with the MMIS contractor to implement the Patient Protection and Affordable Care Act (PPACA) measures for provider screening and enrollment which include site visits, risk based screening, licensure and exclusion checks.
11. The Health Enterprise will incorporate the entire required provider functions.

12. New section four requires the use of predictive modeling and analytics technology to identify and analyze billing or utilization patterns that represent a high risk of fraudulent activity.
13. The requirements of new section four are currently being met through the functionality of the MMIS and are being addressed. Also a system of using predictive modeling and analytics is currently being addressed by the Center for Program Integrity within the Centers for Medicare and Medicaid Services (CMS) based on the testimony on June 7, 2012 of Dr. Peter Budetti, JD, Deputy Administrator and Director for the Center for Program Integrity, CMS:
    a. "CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is required, under the Small Business Jobs Act of 2010, to complete an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and CHIP after the third implementation year of the FPS. Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015. Although Medicaid is administered and organized in a distinctly different way than Medicare, we believe there are opportunities to transfer the knowledge and lessons learned through the FPS and APS in Medicare to States for use in Medicaid. For example, we are currently working to identify specific FPS algorithms that are relevant to Medicaid and will be performing an analysis of one State's Medicaid claims data using the identified algorithms. Once the analysis is complete, we will share the results back with the State. We anticipate the analysis being complete before the end of the year."
14. It is estimated that there will not be a fiscal impact to the agency for implementation of the requirements of this bill for Medicaid because the functionalities, predictive modeling, and analytics required under this bill are already being performed in the legacy MMIS and will be expanded through the development and implementation of Health Enterprise.

Recovery Audit Contract

15. New section five requires the department to contract for the review required under new sections one through five.
16. Under ACA requirements states must contract with a Recovery Audit Contractor (RAC). Montana entered into a contract with a RAC in December 2012 for the analysis of health care claims utilizing analytics and technology to identify aberrant billing of services, based on historical data and algorithms as required under new section four.
17. The RAC currently reviews Medicaid cases for both adults and children but can be expanded to review Children's Health Insurance Program (CHIP) cases under HMK.
18. The RAC contract is a contingency fee contract where the contractor is not paid for services until funds are collected by the department on identified overpayment, fraud, or abuse cases. The funding for these payments is appropriated to the department through a language appropriation in HB 2.
19. Additional appropriation authority would be required to pay the contractor for increased collections for CHIP cases. The department is unable to estimate what these collections would be at this time.

Developmental Disabilities Program

20. Currently the Developmental Disability Program (DDP) does not pay Medicaid payments through the MMIS. This functionality will be incorporated under Health Enterprise when the new system is implemented in the spring of SFY 2015.
21. All DD payments are pre-authorized through the DD-ICP (Individual Cost Plan) system and processed through the AWACS-DDP (Developmental Disabilities Program) system. DDP Case Management payments are processed in the departments AWACS-CSS (Contracts Sub-System).
22. Currently DDP prior-authorizes many services and pre-approves many payments as well as performs federally required quality assurance on all authorization for services, claims, and payments.
23. None of these three systems currently contain the predictive modeling and analytics technology required in new section four of the bill.

24. Numerous programming changes would be required in these systems prior to applying analytics, including adding data fields and predictive modeling of the data.
25. Because there would be new data elements needed in the AWACS-DDP system in order to comply with the bill, there would not be the historical data for modeling and analysis purposes of DDP cases.
26. It is estimated that the programming necessary to meet the requirements of this bill for the DDP systems would take 1,000 hours of contractor time for requirements gathering, design, development, and testing for each system.
27. Significant programming would be necessary in the department's AWACS-CSS. This is not a case management or information management system but is instead a contracts payment system. The AWACS-CSS is a department maintained and operated system. Professional contracted programming and project management services would be required for requirements gathering, design, development, and testing to implement the requirements of this bill in this system. It is estimated that this would require 1,250 hours of professional contracted time.
28. Information technology contracted programming services are estimated to cost $125 per hour.
29. Estimated cost for information technology services to meet the requirements of this bill for DDP services is $406,250.
    a. DD-ICP – 1,000 hours times $125 = $125,000
    b. AWACS-DDP – 1.000 hours times $125 = $125,000
    c. AWACS-CSS – 1,250 hours times $125 = $156,250
    d. $125,000 plus $125,000 plus $156,250 = $406,250
30. Funding will be at the Medicaid Administration match rate of 50% general fund and 50% federal fund.
31. It is estimated that implementation of the required programming for these three systems would not be completed until July 2014. Health Enterprise is scheduled for implementation in the spring of FY 2015.
32. This bill does not include an effective date for implementation of the requirements. If implementation is required beginning in FY 2014, the DD program will not meet this implementation date, but will be compliant by the end of FY 2014.
33. The federal government requires that the federal share of recovery funds for overpayment, fraud, waste, and abuse be returned to the federal government.

	FY 2014 Difference	FY 2015 Difference	FY 2016 Difference	FY 2017 Difference
Fiscal Impact:				
Expenditures:				
Operating Expenses	$406,250	$0	$0	$0
TOTAL Expenditures	$406,250	$0	$0	$0
Funding of Expenditures:				
General Fund (01)	$203,125	$0	$0	$0
Federal Special Revenue (03	$203,125	$0	$0	$0
TOTAL Funding of Exp.	$406,250	$0	$0	$0
Revenues:				
General Fund (01)	$0	$0	$0	$0
Federal Special Revenue (03	$203,125	$0	$0	$0
TOTAL Revenues	$203,125	$0	$0	$0
Net Impact to Fund Balance (Revenue minus Funding of Expenditures):				
General Fund (01)	($203,125)	$0	$0	$0
Federal Special Revenue (03	$0	$0	$0	$0

Technical Notes:

1. If implementation of these requirements of this bill is postponed until the implementation of Health Enterprise, no additional appropriation will be required for information technology predictive modeling and analytics.

Sponsor's Initials	*Date*	*Budget Director's Initials*	*Date*