Complex Medical Add-On

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Executive summary of the initiative and benefits

The new Complex Medical Add-On (CMAO) process provides a 100% elimination of the review and approval for CMAO requests by an Operations & Policy Analyst 3, a registered nurse, along with the elimination of a CMAO specific database, and provides an 80% reduction in the receipt and handling of paper via facsimile. The majority of savings from this event are redeployed to provide industry desired technical assistance regarding complex medical care[1]. The remaining savings are re-deployed to support Complex Medical Add-On utilization audits and other programs.

The CMAO process allows and regulates an enhanced nursing home rate for individuals requiring labor intensive, medically necessary services in excess of normal nursing home services. An average of 400 individuals each month require this enhanced level of care and nursing homes providing this care receive approximately $1.0M[2] in payments, in addition to the basic Medicaid nursing home rate. To support this demand, approximately 12,500 Complex Medical Add-On entries are made annually, due in part to the short term nature of Complex Medical Add-On criteria. The historical process of receive, review, approve, and data entry of complex medical add-on requests is being reduced to only receive and data entry, saving DHS an estimated $70.1K annually to process these requests. Additionally, the current backlog of nearly 6 months of Complex Medical Add-On approvals is being eliminated, saving an additional $13.8K in labor and releasing approximately $6.0M to nursing homes.

The result of this Rapid Process Improvement is $16.8 K in one-time and $70.1K in annual savings with a potential additional annual savings of $45.0K[3]. Information is also being sought from the nursing home industry regarding savings experienced by nursing homes and will be added to this report when it becomes available.

[1] During the Rapid Process Improvement (RPI), the five representatives from the nursing home industry participating in the RPI rated the provision of technical assistance in the utilization of Complex Medical Add-On as the second greatest "value" added by this process, second only to getting paid for the enhanced care.

[2] 400 individuals x 365 days x $80.7 CMAO rate per day = $11.8M annually.

[3] Additional savings are dependent upon eliminating the need to receive and enter Complex Medical Add-On requests or notices. Implementation of this additional savings is dependent upon an acceptable means to track and limit utilization.

Redeployment plan

All benefits realized by Seniors and People with Disabilities will be redeployed within the Licensing and Quality Control unit with most benefits providing complex medical technical assistance to nursing homes[4] or to support utilization audits and recoveries.

Total benefit:	$86.9K
Redeployment:	
CMAO audits, recoveries & sanctions	($ 38.6K)
CMAO technical assistance	($ 40.0K)
Redeployed IT (ISS-7)	($ 7.3K)
Administrative “pooled” resources	($ 1.0K)

Improvement summary

A dedicated fax receives over 6,000 Complex Medical Add-On reports annually which include an average of one complex medical add-on rate increase and one decrease[5], along with at least four additional sheets of paper to provide documentation and justification for each rate increase. These reports are received and logged by a support person. They are then reviewed, approved/denied by a registered nurse and later entered into the payment system by a support staff, making it possible for nursing homes to bill at this additional rate.

The process portion of “review and approve” Complex Medical Add-On requests is being eliminated. Under the new process nursing homes fax/e-mail a notice of CMAO utilization and retain justifying documentation for each individual billed at the enhanced rate. They then provide this documentation, as necessary, to SPD via e-mail as part of a regularly scheduled audit of Complex Medical Add-On use. Sanctions and overpayment recovery are additionally used to assure integrity of nursing home utilization for this enhanced rate.

Additionally, a backlog of approximately 6,000 entries is addressed by piloting a methodology eliminating the need to enter the CMAO requests, allowing nursing homes to directly bill for complex medical services. This method, once demonstrated as sustainable, offers an additional $45K in annual savings.[6] From March 17[7] to April 7, 2010 there were 4,002 Complex Medical Add-On claims submitted of the estimated 6,000 outstanding, releasing nearly $4.1M to nursing

[4] See footnote 1.
[5] 6,000 reports x 1+ rate increase and 1+ rate decrease = 12,500 entries annually
[6] See footnote 2.
[7] Estimated start date of the nursing homes being able to bill directly for Complex Medical Add-On services.

homes. This process is monitored weekly by SPD's Planning and Rate Setting Unit and is viewed well within the anticipated $6.8M[8].

Full transition to this process includes:
a) Elimination of current backlog of CMAO requests (May 2010),
b) Development and implementation of a standardized form/format (August 2010),
c) Modification to nursing home rate tables (TBD),
d) Development and implementation of an audit practice (July 2010),
e) Revision to Oregon Administrative Rules (October 2010), and
f) Implementation of a sanction and recovery practice (September 2010).

Benefit/Outcome description
SPD workload / costs reductions (annualized)

One time savings:
- $ 3.0K IT labor for CMAO database rebuild (ISS-7).[9]
- $ 13.8K Backlog elimination (AS-1)[10].

$ 16.8K One time savings.

Ongoing savings:
- $ 1.0K FAX utilization for CMAO.[11]
- $ 4.0K IT labor to maintain CMAO database (ISS-7).[12]
- $ 48.9K Elimination of review & approve CMAO requests (OPA-3).[13]
- $ 16.2K Elimination of CMAO database & some rework(AS-1). [14]

$ 70.1K Ongoing savings.

$ 86.9K Total first year workload/cost savings

Service / Cycle Time
- Reduced cycle time from a current cycle time of up to 11 months to a cycle time of 5 days[15].

[8] Source: Mike McCormick, Manager, SPD Planning and Rate Setting Unit, e-mail 4/7/10.
[9] Prior to this RPI, a rebuild of the CMAO database had been authorized and was scheduled to begin. As a result of this RPI, this database rebuild has been canceled. The individual assigned to this project estimated the amount of time he had allocated for the rebuild.
[10] Based upon estimated backlog.
[11] Based upon actual annual usage and charges in 2008. Source: Mal McGrory.
[12] Based upon historical and estimated time to support this database.
[13] Based upon "Current" process steps eliminated as a result of RPI.
[14] Based upon "Current" process steps eliminated as a result of RPI.

- Immediate elimination of up to 11 months of back logged documents.
- 0 delays due to insufficient information provided.
- 0 delays due to nursing homes waiting for their designated day to submit CMAO forms.

Quality
- Eliminates errors entered onto CMAO database.
- 30% increase in OPA-3 availability for technical assistance and training to nursing home.[16]

People
- 30% increase in OPA-3 availability for technical assistance and training to nursing homes[17].

Baseline information

Backlog:	6,000 entries[18] valued at $6.0 M to the nursing home industry.
Baseline volume:	48.2 Complex Medical Add-On or discontinuations received daily (12,500 annually)[19].
Baseline quality:	8% of CMAO requests are initially denied or delayed for insufficient or inaccurate documentation[20]. 2% of CMAO requests are denied as not meeting CMAO criteria[21].
Baseline process time:	15.9 minutes per Complex Medical Add-On or discontinuation[22].
New process time:	7.8 minutes per Complex Medical Add-On or discontinuation[23].
Baseline cost:	$8.75 per Complex Medical Add-On or discontinuation entry[24].

[15] Estimated time to enter CMAO requests upon receipt.
[16] See Redeployment of Technical Assistance ($40K) in “Redeployment Plan” based upon savings generated by elimination of “review & approve CMAO requests” by the OPA-3 within “Logic Description”. The 30% increase recognizes some technical assistance routinely provided as part of the review & approve process, which was not able to be independently measured.
[17] See Redeployment of Technical Assistance ($40K) in “Redeployment Plan” based upon savings generated by elimination of “review & approve CMAO requests” by the OPA-3 within “Logic Description”. The 30% increase recognizes some technical assistance routinely provided as part of the review & approve process, which was not able to be independently measured.
[18] Based upon team’s statement they are approximately 6 months behind with all entries having been received, reviewed and approved.
[19] The CMAO weekly report log (9/23/09 – 10/27/09) was used to determine the number of reports received. Number of entries per report was determined based upon a sample of 67 CMAO October 2009 reports. One discontinuation per add-on is assumed.
[20] Based upon CMAO “Adjustment log sheet” (3/1/09 – 10/9/09).
[21] Based upon CMAO “Adjustment log sheet” (3/1/09 – 10/9/09).
[22] See Table 1
[23] See Table 2

New cost: $3.58 per Complex Medical Add-On or discontinuation entry[25].

Logic description[26]

Current cost = $8.75 per Complex Medical Add-On or discontinuation entry.

- $3.874 OPA-3 Cost per entry.
  - .66 FTE = 5.275 min/entry x 12,500 entries/year @ 75% utilization[27].
  - $48,429 = $73,377 annual salary & benefits x .66 FTE.
  - $3.874 = $48,429 / 12,500 entries.

- $4.878 AS-1 Cost per entry
  - 1.33 FTE = 10.62 min/entry x 12,500 entries/year @75% utilization[28].
  - $60,977 = $45,848 annual salary & benefits x 1.33 FTE.
  - $4.878 = $60,977 / 12,500 entries.

- $8.75 $3.874/entry (OPA-3) + $4.878/entry (AS-1).

Future cost = $3.58 per Complex Medical Add-On or discontinuation entry.

- $ 3.58 AS-1 Cost per entry.
  - .98 FTE = 7.8 min/entry x 12,500 entries/year @75% utilization[29].
  - $44,773 = $45,848 annual salary & benefits x .98 FTE.
  - $ 3.58 = $44,773 / 12,500 entries.

One time savings = $16.8K

- $ 3K IT labor for CMAO database rebuild (ISS-7) [30].
  - $ 2,151 Salary (80 hours).
  - $ 878 Employee benefits.

- $ 13.8K Backlog elimination[31].
  - $8,568 Salary (5 min/entry x 6,000 entries @75% utilization rate = .3 FTE).

[24] See "Logic Description" section.
[25] See "Logic Description" section.
[26] A labor utilization rate of 75% is applied for all CMAO staff to incorporate work time not directly attributable to the process, such as meetings, planning, interruptions, etc.
[27] See Table 1
[28] See Table 1
[29] See Table 2.
[30] Prior to this RPI, a rebuild of the CMAO database had been authorized and was scheduled to begin. As a result of this RPI, this database rebuild has been canceled. The individual assigned to this project estimated the amount of time he had allocated for the rebuild.
[31] Complex Medical Add-On requests that have been delayed (backlogged) have a little to no likelihood of having the entry delayed due to eligibility issues. Therefore only 5 minutes of work remains instead of the full 7.8 minutes per entry. See Table 3.

- $5,185 Employee benefits.

Ongoing annual savings = $70.1K

- $ 1.0K FAX utilization for CMAO[32].
  - $ 255 Rent of FAX machine ($26.60/month x .8 x 12 months).
  - $ 456 Print costs (45,639 sheets @ $0.0125/sheet x.8).
  - $ 292 Paper costs ($365 x .8).

- $ 4.0K IT labor to maintain CMAO database (ISS-7).
  - $2,805 Salary (2 hrs/wk x 52 weeks).
  - $1,146 Employee benefits.

- $ 48.9K Elimination of review & approve CMAO requests (OPA-3)[33].
  - $34,288 Salary (5.275 min/entry x 12,500 entries per year @ 75% utilization = .66 FTE).
  - $14,630 Employee benefits.

- $ 16.2K Elimination of CMAO database & some rework (AS-1)[34].
  - $10,067 Salary (2.82 min/entry x 12,500 entries per year @75% utilization = .35 FTE)
  - $6,094 Employee benefits.

$ 86.9K Total workload/cost reductions.

NOTE: All salary rates are based upon the Position Pricing v9d spreadsheet.

Sustainability plan (June 1, 2010 though May 31, 2011)
The sponsor, manager and team lead are ultimately responsible for sustaining the improvements as implemented. The manager reports the status of the implementation progress and sustainability plan to SPD Priorities Team. During each phase of the project, CQIT will support implementation and continue to meet with sponsor and CMAO process owner.

[32] Source: Mal McGrory. Based upon 80% of actual annual usage and charges for 2008. 20% remains as CMAO request/notifications.
[33] Based upon difference between "Current" process steps eliminated as a result of RPI and "Future State" process steps. See Table 1 & 2.
[34] Based on the difference between "Current" process steps eliminated as a result of RPI and "Future State" process steps. See Table 1 & 2.

The implementation of this improvement moves toward a Medicaid industry standard relying upon providers to bill appropriately for prior authorized services. SPD identifies two primary risks associated with this strategy. These risks are:

A) An industry wide increase in appropriately claimed CMAO utilization recognizing some providers provide these services and not sought reimbursement due to the complexity and costs of obtaining authorization. It also recognizes a general trend that hospitals are discharging to nursing homes earlier, thereby using nursing homes for longer recovery periods; and, nursing homes are discharging individuals earlier to long term care alternatives (fewer light care residents). This risk, while tracked, is favorably regarded as unreported claims impact the overall cost of providing care, which in turn impacts the Medicaid rate for all individuals served or becomes buried in non-Medicaid rates.

B) Facility specific inappropriately claimed CMAO utilization (misuse). This risk is addressed by tracking individual facilities' utilization of CMAO and targeting audits for those facilities demonstrating unanticipated or irregular increases in CMAO utilization or a history of inappropriate claims. In addition, SPD intends to use savings generated by this process to provide technical assistance for facilities, including the appropriateness of CMAO claims.

To further monitor and address risks, the SPD Planning and Rate Setting Unit monitors fiscal impact and implementation of this strategy on a weekly or monthly basis. This unit also works closely with the Office of Payment Accuracy and Recovery to potentially increase their auditing practice in this area.

Key dates include:

- Elimination of backlog (December 2009 – May 2010),
- Development and implementation of standardized form/format (March 2010 – August 2010),
- Development and implementation of an auditing practice (March 2010 – July 2010),
- Development and implementation of a recovery practice (July 2010 – September 2010),
- Oregon Administrative Rule revisions (April 2010 – October 2010).

Ongoing metrics for the next 12 months

- Utilization of Complex Medical Add-On Rate (to assure utilization of this rate remains within budget and forecasted growth).

- Complex Medical Add-On misuse (to track frequency and sources of misuse as determined by auditing of payments made).
- Payment lag (to assure payments remain timely).
- Absolute dollars recovered due to documentation errors (to guide technical assistance in documentation sufficiency).
- Absolute dollars recovered due to misuse (to guide technical assistance in policy application).

These metrics will be maintained by the process owner, the manager responsible for the CMAO unit, the SPD Planning and Rate Setting Unit and the sponsor.

Annualized projection amount

- $ 1.0K FAX utilization for CMAO[35].
- $ 4.0K IT labor to maintain CMAO database (ISS-7) [36].
- $ 48.9K Elimination of review & approve CMAO requests (OPA-3) [37].
- $ 16.2K Elimination of CMAO database & some rework(AS-1) [38].

$ 70.1K Ongoing savings.

Attachments:

☐ Data Spreadsheet

☐ Reinvestment Plan

☐ Business Case

References and Attachments:

- Table 1: Current State metrics by process steps
- Table 2: Future State metrics by process steps
- Table 3: Backlog metrics by process steps remaining
- "Current State" process map demonstrating process steps identified in Tables 1, 2, & 3

[35] Based upon 80% of actual annual usage and charges in 2008. Source: Mal McGrory.
[36] Based upon historical and estimated time to support this database.
[37] Based upon "Current" process steps eliminated as a result of RPI.
[38] Based upon "Current" process steps eliminated as a result of RPI.

- Attachment from 4/2/10 e-mail by Mike McCormick, Manager, SPD Planning and Rate Setting Manager
- E-mail from Mike McCormick, Manager, SPD Planning and Rate Setting Manager dated 4/7/10.

References:

Table 1: Current State[39]

Current State:

Step	Time	Frequency	Proportion	Adjusted Time	OPA-3 Time	AS-1 Time
1	0	1	0.5	0		0
2	8	1.1	0.5	4.4	4.4	
3	4	0.1	0.5	0.2	0.2	
4	1	0.1	0.5	0.05		0.05
5	0	1	1	0	0	
6	0	1	1	0		0
7	2	1.2	1	2.4		2.4
8	4	0.2	0.5	0.4		0.4
9	0	0.2	0.5	0		0
10	15	0.1	0.5	0.75		0.75
11	0	0.09	0.5	0		0
12	15	0.09	0.5	0.675	0.675	
13	0	0.09	0.5	0		0
14	4	0.01	0.5	0.02		0.02
15	4	1	1	4		4
16	2	1	1	2		2
17	1	1	1	1		1
18	0	0.1	0.5	0		0
				Total:	5.275	10.62
				Accum Time:		15.895

Table 2: Future State

Future State

Step	Time	Frequency	Proportion	Adjusted Time	OPA-3 Time	AS-1 Time

[39] "**Step** = the step in the process as identified in the "Current State Map" which is included after Table 3. **Time** = the "touch time" or duration required to complete the identified step, as determined by staff interviews. **Frequency** = how often this step occurs, reflecting any rework or occurrences when this step isn't required. **Proportion** = some steps are only required when the additional rate is being added, others are only required when the additional rate is being removed. Therefore "1" indicates the step is applied for both instances, whereas ".5" indicates the step is required for one, but not both. **Adjusted Time** = "Time" x "Frequency" x "Proportion". **OPA-3 Time** = the step and corresponding time being attributed to the OPA-3 classification**. AS-1 Time** = the step and corresponding time being attributed to the AS-1 classification.

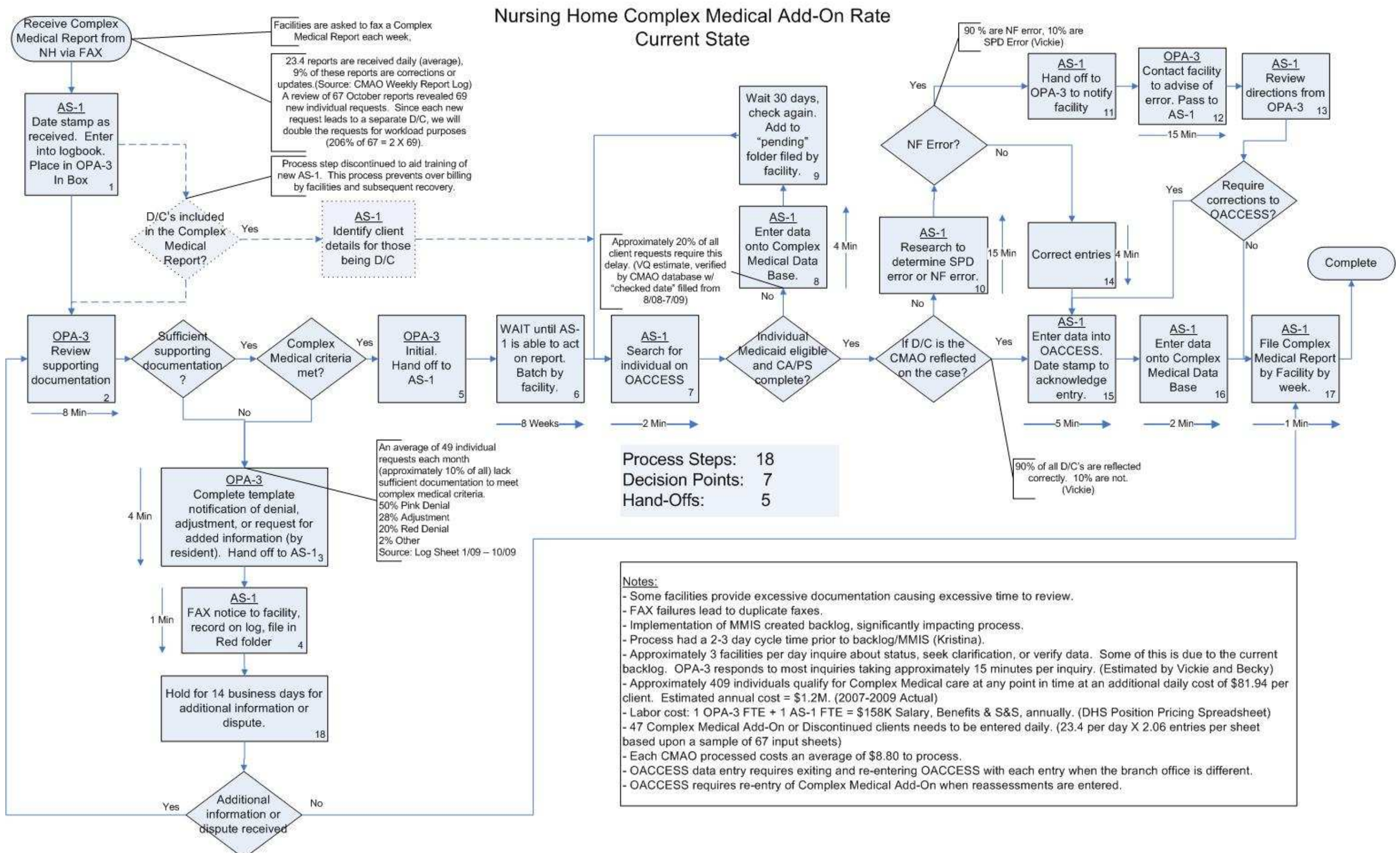
Step	Time	Frequency	Proportion	Adjusted Time	OPA-3 Time	AS-1 Time
1	0	1	0.5	0		0
2	0	1.1	0.5	0	0	
3	0	0.1	0.5	0	0	
4	0	0.1	0.5	0		0
5	0	1	1	0	0	
6	0	1	1	0		0
7	2	1.2	1	2.4		2.4
8	4	0.2	0.5	0.4		0.4
9	0	0.2	0.5	0		0
10	0	0.1	0.5	0		0
11	0	0.09	0.5	0		0
12	0	0.09	0.5	0	0	
13	0	0.09	0.5	0		0
14	0	0.01	0.5	0		0
15	4	1	1	4		4
16	0	1	1	0		0
17	1	1	1	1		1
18	0	0.1	0.5	0		0
				Total:	0	7.8
				Accum Time:		7.8

Table 3: Backlog

Backlog

Step	Time	Frequency	Proportion	Adjusted Time	OPA-3 Time	AS-1 Time
1	0	1	0.5	0		0
2	0	1.1	0.5	0	0	
3	0	0.1	0.5	0	0	
4	0	0.1	0.5	0		0
5	0	1	1	0	0	
6	0	1	1	0		0
7	0	1.2	1	0		0
8	0	0.2	0.5	0		0
9	0	0.2	0.5	0		0
10	0	0.1	0.5	0		0
11	0	0.09	0.5	0		0
12	0	0.09	0.5	0	0	
13	0	0.09	0.5	0		0
14	0	0.01	0.5	0		0
15	4	1	1	4		4
16	0	1	1	0		0
17	1	1	1	1		1
18	0	0.1	0.5	0		0
				Total:	0	5
				Accum Time:		5

Note: Process steps identified in the above tables may be directly referenced to the "Current State" map below.



Complex Medical Liability Estimate[40]

I obtained compiled CMAO information from the CMAO Unit. I determined:

- 49 facilities submitted spreadsheets claiming they did not get paid.
- Facilities asserted approximately 35,000 days were not paid.
- 46.4% of the days were prior to July 1, 2009.
- 53.6% of the days were after July 1, 2009

I then selected a random sample of 30 line items from the compiled spreadsheets. I found that:

- Three (10%) had been paid nothing.
- Two (6.6%) had already been reimbursed for complex medical
- Twenty-five (83.3%) had been reimbursed for the basic rate, meaning only the difference between complex medical and basic rates (~$81 per day) is due.

[40] Source: Mike McCormick, e-mail attachment sent to Michael Bellish on 4/2/2010.

I then applied these percentages as follows:

Category	Total Days	Percentage	Weighted Amt Due per day	Liability
Paid Nothing	35,564	10%	$284.30	$1,011,084.52
Paid Already	35,564	6.66%	$0.00	$0.00
Paid Basic Only	35,564	83.34%	$80.7	$2,391,870.33
			Total	$3,402,954.85

Unknowns

The attached PDF document shows that, on average, 110 NFs bill complex medical each month. This remained constant both pre and post implementation of the new MMIS. Additionally, complex medical utilization has actually risen since the implementation of the new MMIS. This is puzzling since there is an apparent CMAO backlog and consistent assertions from facilities that they're not getting paid. A definitive diagnosis on why complex medical utilization rose needs to be made.

Further, if we assume that the 49 facilities submitting CMAO spreadsheets only represents half of the facilities for which payment is due, the $3.4M liability should be doubled to $6.8M. If we apply a 30% GF rate to the $6.8M, the GF liability is just over $2M.

Recommendation

Open up CMAO from 3/1-5/31
Resume clerical posting on 6/1
Becky diagnose high utilization during month of March.

From: Mike R McCORMICK
To: BELLISH, Michael R
Date: 4/7/2010 7:54 AM
Subject: Fwd: CMAO Update

I just saw your face and thought this might be of interest to you!

>>> Mike R McCORMICK 4/6/2010 10:38 AM >>>

The relaxed controls on CMAO billing have been in place since approx March 17th. The word got out and facilities are taking this opportunity to mostly adjust old claims that have been paid at the basic rate.

Week Ending	Claims Submitted	Total Claim Value	Net Payments Issued
19-Mar-10		$ 4,540,290	$ 1,234,540

	1,052		
26-Mar-10	2,092	$ 8,789,569	$ 2,416,173
02-Apr-10	858	$ 4,113,009	$ 423,772

To help you interpret the table, for the week ending March 19th, there were 1,052 new or adjusted claims submitted. These claims were adjudicated with a total value of $4,540,290. $3,305,750 was previously paid. Therefore, net payments amounted to $1,234,540 for CMAO that week.

The bottom line is that I'm not seeing anything of concern. I will continue to monitor this closely each week. To remind you, I estimated that the total cost of clearing the backlog would be in th $6.8M total fund range. To date, approx $4M has gone out. For perspective, we expect the total value of CMAO claims to be between $3.5-$3.9M each month. The $6.8M backlog gets distributed over all of those past months in little chunks.

I am also having the kickoff meeting with OPAR this afternoon. They're going to do enhanced monitoring I don't have time to do. They'll also be feeding audit files to Becky.

Let me know if you have questions,
Mike