FINAL REPORT

Communications Regarding a Computer System Weakness Resulting in MaineCare Claims Payments for Ineligible Individuals – DHHS MIHMS Project Staff Knew of Issue in 2010, But Executive Management Knowledge of the Issue and Its Impact was Limited Until Early 2012

Report No. RR-DHHS-12

Issues OPEGA noted during this review:

- MIHMS Project Management Role in Guiding and Escalating Project Decisions and Issues was Unclear (pg. 19)
- Steering Committee Role and Purpose was Undefined (pg. 19)
- MIHMS Project Team Lacked Effective Process for Prioritizing System Issues (pg. 19)
- Communication Issues Contributed to the Ineligible Segments Issue Not Being Addressed Earlier (pg. 20)

November
2012

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

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Acronyms Used in This Report

ACES	Automated Client Eligibility System
AFA	Joint Legislative Committee on Appropriations and Financial Affairs
BDS	Department of Behavioral and Developmental Services
CMS	Federal Centers for Medicare and Medicaid Services
CHIP	Children's Health Insurance Program
CIO	Chief Information Officer
COO	Chief Operating Officer
COTS	Commercial Off-the-shelf
CR	Change Request
DAFS	Department of Administrative and Financial Services
DDI	Development, Design, and Implementation
DEL	Low Cost Drugs for the Elderly and Disabled Program
DHHS	Department of Health and Human Services
GOC	Government Oversight Committee
HIPAA	Health Insurance Portability and Accountability Act Privacy and Security Rules
IV&V	Independent Verification and Validation Contractor
MECMS	Maine Claims Management System
MHDO	Maine Health Data Organization
MIHMS	Maine Integrated Health Management System
OFI	Office of Family Independence
OFPR	Office of Fiscal and Program Review
OIT	Office of Information Technology
OMS	Office of MaineCare Services
PCCB	Project Change Control Board
RAC	Recipient Aid Category
SME	Subject Matter Expert
SFY	State Fiscal Year
TR	Trouble Report

Communications Regarding a Computer System Weakness Resulting in MaineCare Claims Payments for Ineligible Individuals – DHHS MIHMS

Project Staff Knew of Issue in 2010, But Executive Management Knowledge of the Issue and Its Impact was Limited Until Early 2012

Introduction

A MaineCare computer system weakness caused over $10.6 million in improper payments from 2010 to 2012 and artificially inflated the MaineCare caseload by 19,000 members.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of communications in the Executive and Legislative Branches regarding a computer system weakness resulting in MaineCare claims payments for ineligible individuals. MaineCare provides health insurance to certain low income residents of Maine through Medicaid and other programs. The administration of MaineCare payments is the responsibility of Maine's Department of Health and Human Services (DHHS), Office of MaineCare Services (OMS). This review was performed at the direction of the Government Oversight Committee (GOC) for the 125th Legislature.

Legislative interest in this issue arose because DHHS revealed it after the Legislature had considered controversial cuts to MaineCare to address a $121 million budget shortfall.

The computer system weakness, known as the ineligible segments issue, caused over $10.6 million[1] of improper payments from September 2010 to March 2012 for 7,730 ineligible individuals, and artificially inflated the MaineCare caseload by 19,000 members. The ineligible segments issue and its implications were not reported to the Legislature by DHHS until early March 2012, after the Joint Standing Committee on Appropriations and Financial Affairs (AFA) had spent considerable time weighing controversial cuts to MaineCare eligibility proposed by the Governor in the wake of an estimated $121 million MaineCare funding shortfall for State fiscal year (SFY) 2012. This prompted legislator questions and concerns about the information DHHS chose to share with the Legislature.

OPEGA's review focused on who in government knew what and when about the issue.

OPEGA's review focused on human communications within the Executive Branch, between the Executive Branch and the contractors on the MIHMS project, and between the Executive and Legislative branches related to the ineligible segments issue. OPEGA did not examine the methodology DHHS used to identify the caseload and financial impact of the issue, and therefore cannot assess the accuracy of these figures or the reasonableness of the time it took DHHS to derive them. The GOC approved the scope questions addressed by OPEGA prior to the review's initiation. See Appendix A for complete scope and research methods.

[1] The State share of these payments amounted to approximately $6.8 million, with the remainder—approximately $3.8 million—paid by the federal government. As of November 2012, DHHS does not know what portion, if any, of the federal funding will have to be repaid. DHHS made the policy decision not to recoup the improper payments from providers.

Questions, Answers, and Issues

1. Who knew what, and when, within the management ranks of the Executive Branch regarding the fact the ACES and MIHMS systems could not interface directly with each other?

When OPEGA was assigned this review, we believed DHHS' Automated Client Eligibility System (ACES) and the MaineCare claims system (the Maine Integrated Health Management System, or MIHMS) were expected to directly interface with each other. In fact, MIHMS is designed to interface with multiple other external eligibility systems via a system known as the Data Hub, which was built by the State's Office of Information Technology (OIT) as part of the MIHMS project.[2] The Data Hub processes information from these external eligibility systems and puts it into a format that can be read by MIHMS. Consequently, the nature of the problem that led to inaccuracies in caseload data and payments for ineligible individuals is somewhat different, and more complicated, than originally assumed. DHHS has termed this the "ineligible segments issue," and this was the focus of our review.

DHHS had established processes and procedures for documenting and reporting MIHMS issues up the chain of command and for tracking actions required to correct system problems. In the case of the ineligible segments issue, information about the issue and its potential impact was documented and reported appropriately by DHHS staff in August 2010 and raised again by DHHS staff in March 2011. However, this information was not escalated beyond the DHHS MIHMS Project Manager to the MIHMS Steering Committee. The DHHS MIHMS Project Manager told OPEGA this issue was not given priority because DHHS was dealing with a multitude of other MIHMS issues.

The issue did not come to the attention of the Commissioner of DHHS until late December 2011 when concerns surfaced that indicated the ineligible segments issue had a substantial impact. Over the next two months the Commissioner regularly sought explanations from DHHS staff and reliable estimates of the financial and caseload impacts of this issue. She informed the Governor's Office of the issue at the end of February 2012.

2. What actions did Executive Branch management take to ensure the problem was corrected or the potential impacts were monitored?

Due to the multitude of other MIHMS issues, DHHS did not devote resources to immediately resolving the ineligible segments issue after it was identified in August 2010, or to determining the caseload and financial impact of the issue. DHHS told OPEGA that during this period the MIHMS project team was working to address 159 other issues, including 90 which—like the ineligible segments issue—were classified as "severe". DHHS had no effective method in place for identifying which among these issues was most pressing or should be fixed first; that was left to the contractor Molina's discretion.

[2] ACES determines eligibility for all DHHS programs with a few exceptions. Information for foster children and some older adults is gathered and housed in separate data systems. Those systems also interface with MIHMS via the Data Hub.

The MIHMS project team was able to determine by March 2011 that the issue affected over 23,000 members; however, not all affected members were necessarily ineligible. DHHS was unable to easily identify the number of ineligible individuals receiving benefits or the resulting financial impact. DHHS did not monitor the number of affected members after this initial estimate.

The issue was placed on a list of issues to be addressed by the State's contractor, Molina, but the contractor struggled to implement the fix to address it. As a result, DHHS management approved a new change request for OIT to implement a fix within the Data Hub. Testing of this fix took OIT and Molina several months from mid to late 2011. OPEGA found no indication that management took action to expedite the fix although the issue remained unaddressed. The Data Hub fix was put into production in December 2011 but failed; it was successfully implemented in March 2012. The contractor's fix to this issue within MIHMS is still outstanding as of November 2012.

3. Were the Legislature's Appropriations and Financial Affairs and Health and Human Services Committees made aware of this problem and its financial impact prior to March 2012, and if not, why not?

DHHS did not inform the Legislature's AFA and Health and Human Services (HHS) Committees about the ineligible segments issue until March 9, 2012. The Commissioner of DHHS was not made aware of the issue until late December 2011. She told OPEGA that during January and February 2012, she did not have confidence in the reliability of data she was receiving from her staff on the estimated caseload and financial impact of the issue. She was not willing to report potentially unreliable information to the Legislature and the Governor. Emails OPEGA reviewed showed the Commissioner was asking her staff for information on the impact of the issue throughout this period.

The Legislature was first made aware of the precise financial impact of this issue in April 2012. DHHS staff told OPEGA that calculating the financial impact was difficult and time consuming, and they were unable to produce an accurate estimate more quickly. DHHS told OPEGA they held twice daily meetings in March and April with DAFS (including OIT), the Office of the State Controller, and MIHMS contractors to discuss progress in quantifying the financial impact of issue.

OPEGA identified the following issues of concern during the course of this review. See pages 19 - 21 for further discussion.

- MIHMS Project Management Role in Guiding and Escalating Project Decisions and Issues was Unclear
- Steering Committee Role and Purpose was Undefined
- MIHMS Project Team Lacked Effective Process for Prioritizing System Issues
- Communication Issues Contributed to the Ineligible Segments Issue Not Being Addressed Earlier

In Summary

DHHS implemented a new MaineCare claims system (MIHMS) in 2010. The system encountered many issues after it came online.

The Maine Integrated Health Management System (MIHMS) is the State's MaineCare (Medicaid) claims processing system. In 2008, DHHS contracted with Molina (formerly Unisys) to design, deploy, and operate MIHMS to replace the prior claims system, MECMS[3], which had experienced significant problems. Proceeding on an aggressive timeline, MIHMS went live on September 1, 2010.

Immediately the system had a number of problems which necessitated interim provider payments and generated numerous complaints. Molina struggled to address the growing number of system issues. DHHS prioritized correcting those issues that impacted accurate and timely payments to MaineCare providers and federal certification of MIHMS. DHHS also experienced turnover in MIHMS project management and staff in the months following go-live.

One problem known as the ineligible segments issue caused eligibility to remain open for individuals who were no longer eligible.

One system flaw, known as the "ineligible segments issue," resulted in MaineCare claims payments for ineligible individuals and artificially inflated the MaineCare caseload. It caused some MaineCare members who had become ineligible to remain eligible in MIHMS indefinitely unless the record was manually corrected. The possible consequences of this flaw were identified by a DHHS MIHMS project team member in August 2010.

DHHS project staff followed MIHMS project procedures by documenting the problem, with its potential implications, and generating a formal change request (CR) for Molina to fix it. The CR was approved by the MIHMS Project Change Control Board for Molina to address; however, there were a multitude of competing system issues needing attention at this time, and Molina struggled to implement a fix to the ineligible segments issue due to its complexity.

Molina struggled to implement a fix to the issue due to its complexity and the multitude of other issues after go-live.

In March 2011, the MIHMS project team member who originally identified the ineligible segments issue followed up with project management to stress the importance of implementing a fix. He documented the affected number of MaineCare members and reiterated that the issue was causing some claims to be paid for ineligible individuals, although he was unable to estimate the magnitude. Project management prioritized the issue by placing the CR on the MIHMS Stabilization List. However, DHHS staff told OPEGA there was no effective method in place for determining which issues on the list were most important; instead, this was left up to Molina. In May 2011, DHHS approved work on a new fix in the Data Hub, a system which transfers member information from the MaineCare eligibility system (ACES) to MIHMS. Testing of this fix began in August 2011. It was put into production in December 2011, but did not work properly. It was successfully implemented in March 2012.

MIHMS project management was aware of the issue from at least March 2011, but did not escalate it.

MIHMS project management was aware of the ineligible segments issue and the fact that it was resulting in improper claims payments from at least March 2011 on. However, the DHHS MIHMS Project Manager did not bring this specific issue to the attention of the MIHMS Steering Committee or DHHS executive management. As mentioned, at the time there were a multitude of other MIHMS issues, and this was one of many the project team was working to address.

[3] The Maine Claims Management System

During the summer and fall of 2011, DHHS encountered inconsistencies in MaineCare caseload data when MIHMS became the new caseload data source. DHHS believed inconsistencies resulted from differences in how the former and new data sources counted members eligible in multiple benefit categories. The DHHS Commissioner reported to the Legislature that the Department was working to resolve these inconsistencies. Caseload data reported to the Legislature was adjusted multiple times over this period as a result of these efforts.

Those working on correcting caseload reporting at DHHS were not aware that the ineligible segments flaw was also affecting caseload figures being generated by MIHMS. Because ineligible segments affected many MaineCare benefit categories, total caseload was higher, but increases in any one category were small and difficult to trace. There was no apparent pattern to the scattered increases that would explain a larger total. In addition, DHHS' adjustments to the caseload data somewhat masked the extent to which overall caseload numbers were increasing. The Department released caseload data regularly to the Legislature and its Office of Fiscal and Program Review (OFPR) throughout 2011, and OFPR continued to question DHHS about the data. The DHHS Office of MaineCare Finance told OPEGA that by September 2011 they were confident the MIHMS data was accurate.

DHHS executive management was unaware of the issue until late 2011 when several events brought its impact to light.

Because the ineligible segments issue was not escalated beyond the DHHS MIHMS Project Manager and DHHS was not receiving complaints related to the issue from providers, DHHS executive management, including the Commissioner, was unaware of the issue until late 2011 when several events brought the impacts of the issue to light. These events included:

- questions raised about the accuracy of caseload data by the Maine Health Data Organization (MHDO) and legislative staff;
- unrealized cost savings expected in the Office of Family Independence;
- questions from the State Auditor's Office about the cause of claims payments for ineligible members identified in their annual testing of a sample of Medicaid and Children's Health Insurance Program (CHIP) claims; and
- data seen during testing of the ineligible segment fix.

The DHHS Commissioner told OPEGA she did not notify the Legislature of the issue until March 2012 because she was not confident the Department had accurate impact data to share.

In January 2012, the Commissioner tasked MIHMS project staff members with determining the financial and caseload impacts of the issue. DHHS staff prepared a caseload impact estimate in late January and a financial impact estimate in early February. The Commissioner told OPEGA she decided not to share these estimates with the Legislature at that time because she did not have confidence in their accuracy.

The Commissioner briefed the Governor's staff on the issue for the first time on February 28, 2012, and met with the Governor the next day. The Governor's staff told OPEGA they immediately notified Legislative leadership of the problem. On March 2, the Governor met with several DHHS staff members, the State Chief Information Officer (CIO), the State Controller, and the MIHMS contractors. He directed OIT and the Controller to help DHHS calculate the financial impact of the issue.

At the next scheduled AFA meeting on March 9, 2012, DHHS told AFA that the MaineCare caseload was incorrectly inflated by 19,000 members and the Department was working to quantify the financial impact of claims paid for ineligible members. On April 27, 2012, DHHS informed the Legislature that over $10.6 million had been paid for 7,730 ineligible members. Although the DHHS Commissioner could have made AFA aware of the ineligible segments issue when it came to her attention in January 2012, there was little information she could have shared on the magnitude of the issue or its potential impacts on the MaineCare budget which the Legislature was addressing at that time.

OPEGA noted concerns within the MIHMS project that contributed to the issue not being highly prioritized or reported to the Commissioner earlier, but did not gather sufficient information in this limited scope review to make specific recommendations.

In conducting this review, OPEGA identified issues we believe contributed to this system flaw not being prioritized more highly or reported to the Commissioner earlier. We did not gather sufficient information for making recommendations related to these issues which were beyond the scope of this review. Nonetheless, we believe they warrant DHHS' consideration regarding MIHMS and future system projects. These concerns are in the following areas:

- MIHMS Project Management
- Steering Committee Effectiveness
- Issue Prioritization
- Communication within the MIHMS Project Team, and between the MIHMS Project Team and Executive Management

Background

The Maine Integrated Health Management System (MIHMS)

The State's new MaineCare claims processing system (MIHMS) was put into place on an expedited timeline after significant problems occurred with the previous system.

All MaineCare claims are processed and paid through the Maine Integrated Health Management System (MIHMS). MIHMS replaced the previous system, the Maine Claims Management System (MECMS), which was put into place in 2005. DHHS initiated the MIHMS project after several years of significant problems with MECMS, including failure to properly process claims and pay providers.[4]

DHHS also chose to pursue a new claims system because they were unable to obtain federal certification of MECMS. Federal certification validates that the system is operating as reported, in compliance with all federal requirements, and in a manner that allows the program to operate efficiently and effectively. States with certified Medicaid claims payment systems receive a higher federal match rate for system operations costs, applied retroactively to the date the system went into operation. With a certified system, Maine receives a 75 percent match for operations expenses. Under MECMS, which was not certified, DHHS received only a 50 percent match for operations expenses.

In 2008, DHHS contracted with Unisys Corporation (now Molina) to design, deploy, and operate MIHMS. Molina developed MIHMS based on an existing, commercial off-the-shelf (COTS) system that was modified to fit the State's

[4] OPEGA's 2005 Report titled "Review of MECMS Stabilization Reporting" describes problems the State encountered with MECMS.

MIHMS was designed and is operated by contractor Molina, to whom the State has also outsourced MaineCare claims processing and payments.

requirements. Choosing a COTS system allowed the State to leverage Molina's existing resources to shorten the time for system development and design.

In contracting with Molina, the State also chose to move to a "fiscal agent" model, meaning the payment of MaineCare claims was outsourced to Molina. This represented a shift in the State's approach to MaineCare claims processing, and was influenced by serious problems the State had encountered in paying providers under MECMS.

MIHMS encountered significant problems after go-live but received federal certification in December 2011.

The State chose to proceed with MIHMS on an aggressive timeline. The contract with Molina was signed in February 2008 and design work started immediately thereafter. MIHMS go-live was originally scheduled for April 1, 2010, but was delayed twice to allow additional time for testing. MIHMS went online September 1, 2010 and, despite encountering significant problems after go-live, received federal certification in December 2011, retroactive to September 2010.

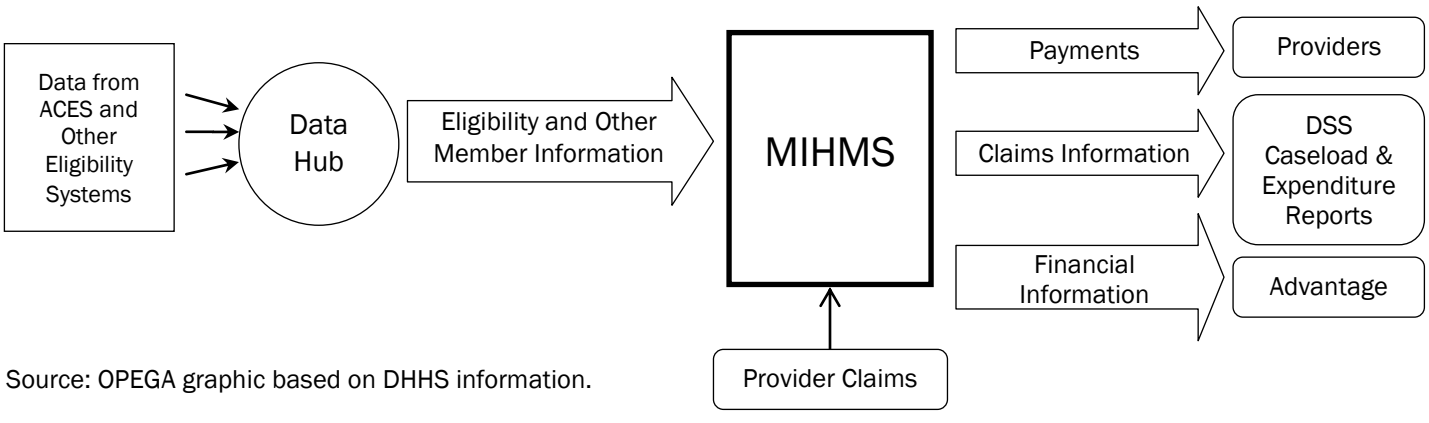
MIHMS Interfaces with Other Systems

MIHMS is designed to interface with external eligibility systems via a data processing system known as the Data Hub.

MIHMS was not designed to interface directly with the other external systems DHHS uses to gather member data and eligibility information. This data, which is collected via other systems such as the Automated Client Eligibility System (ACES), must be processed before it can move into MIHMS. OIT was tasked with designing a system known as the Data Hub to process information from the external systems for entry into MIHMS. Proper interfaces between the external systems and the Data Hub, and between the Data Hub and MIHMS are critical to ensuring claims are paid properly.

Figure 1 below shows how client information moves through MaineCare data systems. The Decision Support System (DSS), which is part of MIHMS, generates MaineCare expenditure and caseload reports provided to the Legislature. OFPR utilizes information from Advantage, the State's accounting system, to track and analyze MaineCare spending for the Legislature.

Figure 1: MIHMS Interfaces



Source: OPEGA graphic based on DHHS information.

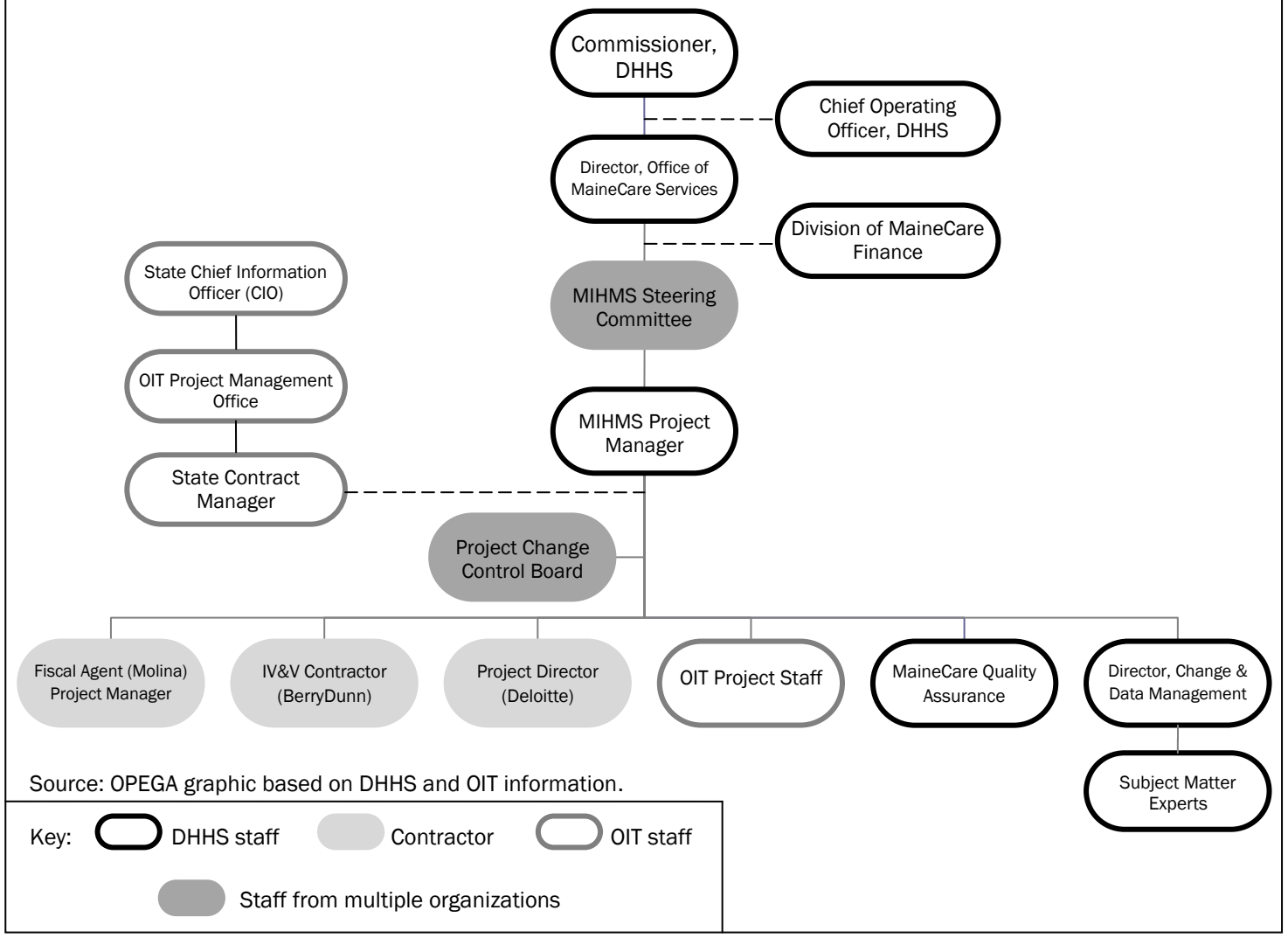
MIHMS Project Team Structure and Responsibilities

The MIHMS project team includes staff from a multitude of organizations, including contractors.

The MIHMS project team includes staff from multiple organizations, including DHHS, OIT, and consultants Molina (system design and operation), Deloitte (project director), and BerryDunn (Independent Verification and Validation, or IV&V). The MIHMS project team is overseen by the OMS Director and governed by the MIHMS Steering Committee. Individuals from both OIT and DHHS work under the DHHS MIHMS Project Manager, with OIT staff providing programming expertise and DHHS staff providing expertise on MaineCare. Contractors report to the DHHS MIHMS Project Manager, while the State Contract Manager in OIT ensures they are complying with contract terms.

Figure 2 shows the key members of the MIHMS project team and reporting relationships for the time period OPEGA reviewed, through April 2012. DHHS has since made changes which are detailed in their agency response letter.

Figure 2: MIHMS Project Organization through April 2012



Source: OPEGA graphic based on DHHS and OIT information.

The roles and responsibilities of the primary actors discussed in this report were as follows:

Subject Matter Experts identified and documented MIHMS issues.

Change Management Group and Subject Matter Experts. The Change Management Group includes Subject Matter Experts (SMEs) who report to the Director of Change and Data Management. Due to regulatory, policy, and eligibility changes, DHHS is constantly updating MIHMS. Change management encompasses these updates, as well as those needed to make the system function properly. The Change Management Group and SMEs are responsible for interpreting State and federal requirements and identifying the necessary changes to MIHMS. SMEs are experts on various aspects of MaineCare requirements, such as eligibility, and write the rules that guide Molina in making programming updates to the MIHMS system. These changes are documented by the Change Management Group in a database (see further information under "Tracking of MIHMS Issues" on page 10). SMEs also work with Molina to ensure the system design is correct and functioning properly.

DHHS contracted with several outside entities to perform various functions on the MIHMS project.

Contractors. DHHS contracted with several outside entities to perform various functions on the MIHMS project. Molina was awarded the contract to design and operate the MIHMS system and serve as the MaineCare fiscal agent, managing claims payments on an ongoing basis. Deloitte provided a Project Director to support the DHHS MIHMS Project Manager by offering subject matter expertise on managing large data systems and ensuring project deadlines were met. BerryDunn was contracted to fill the Independent Verification and Validation (IV&V) role. In this capacity, BerryDunn served as the independent third party responsible for identifying and reporting system issues, reviewing and assessing the adequacy of Molina deliverables, helping ensure MIHMS was on track for federal certification, and monitoring MIHMS project processes prior to go-live to ensure they were followed. BerryDunn served in an advisory role but did not make decisions. BerryDunn provided regular written reports to DHHS identifying and tracking key concerns and issues with the MIHMS system.

The DHHS MIHMS Project Manager was responsible for managing project staff and contractors; leading the Project Change Control Board (PCCB); and escalating issues beyond the PCCB up the chain of command.

DHHS MIHMS Project Manager. In addition to managing the MIHMS Project staff and contractors, the DHHS MIHMS Project Manager is responsible for leading the Project Change Control Board (PCCB). According to the MIHMS Project Change Management Plan, the DHHS MIHMS Project Manager is responsible for submitting change requests that impact project scope to the PCCB, for approving change requests (CRs) for work, and escalating CRs to the Steering Committee in certain instances, for example, if there is a significant financial or operational impact on the project. As noted on page 13, the ineligible segments issue was not escalated to the Steering Committee.

Project Change Control Board. The PCCB is responsible for review, approval, and prioritization of requested changes. The PCCB is comprised of the DHHS MIHMS Project Manager, Change and Data Management Director, State Contract Manager, and individuals from Molina. DHHS told OPEGA that during the period reviewed, the PCCB met at least once per week.

A Steering Committee governed the MIHMS project, but OPEGA was unable to clearly identify the overall purpose and specific responsibilities of this Committee.

MIHMS Steering Committee. The MIHMS Project is governed by a Steering Committee. The Committee was comprised of DHHS management, including the Chief Operating Officer (COO), OMS Director, DHHS MIHMS Project Manager, Director of MaineCare Finance, and Director of Change and Data Management. Individuals from the OIT Project Management Office also attended these meetings. Staff from Molina, Deloitte, and BerryDunn[5] participated in meetings and presented information as requested by DHHS. The Steering Committee met weekly.

It was unclear to OPEGA who led the Steering Committee or set its agendas during the time period that was the focus of this review. DHHS told OPEGA that, under their contracts, Molina and Deloitte were responsible for leading the meetings and choosing what issues would be presented. OPEGA reviewed Steering Committee meeting minutes, but minutes were not taken consistently, and we had difficulty discerning the overall purpose and specific responsibilities of the Steering Committee, and who guided its meetings. In addition, attendees OPEGA talked with provided varying descriptions of the Committee's work. DHHS does not have guidance in place directing the work of the Committee or outlining its goals. OPEGA did not seek to assess the overall effectiveness of the Steering Committee, as we considered this outside the scope of our review; however, DHHS staff did share their perceptions that the Steering Committee was not as effective as it might have been.

Tracking of MIHMS Issues

MIHMS issues are documented and tracked in a database, then discussed and in some cases escalated by project management.

Molina developed a database that allowed for tracking issues that arose in MIHMS. These issues are classified into two categories: trouble reports (TRs) and change requests (CRs). If the system had a function that was not working as designed, DHHS staff would create a TR. Molina was responsible for the cost of fixing TRs because they resulted from problems in Molina's design or development of the system. If an issue resulted from some action or decision on the DHHS side, a CR was created. The State was typically responsible for the cost of fixing CRs because they resulted from a change requested by DHHS, for example, due to a change in the rules for MaineCare eligibility.

TRs and CRs were identified by SMEs who would enter them in the database and inform the Director of Change and Data Management. The DHHS MIHMS Project Manager then met with the PCCB to discuss and approve CR and TRs for work, and in some cases escalate them to the Steering Committee level for further discussion. Once approved for work, a CR or TR's status would be changed to development followed by testing, deployment and closure.

[5] The State's contract with BerryDunn ended in July 2012 and therefore they no longer participate in Steering Committee meetings.

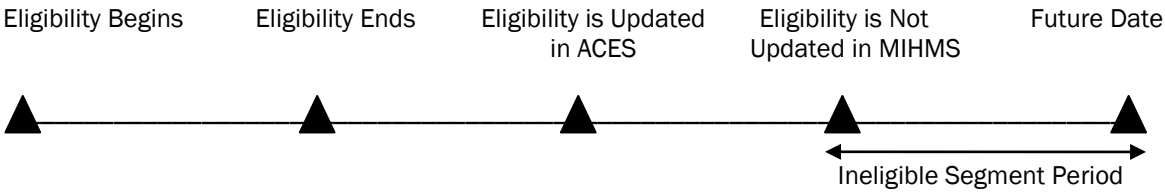
The Ineligible Segments Issue

The ineligible segments issue prevented MIHMS from properly closing MaineCare eligibility for members that became ineligible in certain instances.

This review focused on DHHS knowledge related to the impact of the ineligible segments issue, a MIHMS system flaw which allowed claims to be paid for ineligible members and artificially inflated the MaineCare caseload. Key events discussed in the following sections of this report are presented in timelines in Appendix B.

Figure 3 illustrates the ineligible segments issue, which occurred in those cases where eligibility end dates in ACES were retroactive by the time they reached MIHMS. Due to a mistake in the way the MaineCare eligibility rules were written for MIHMS, MIHMS would not properly close eligibility for members who became ineligible retroactively, thus leaving the member's original eligibility end date unchanged. Therefore the member's eligibility for MaineCare remained open, although they were ineligible.[6]

Figure 3. Ineligible Segment Period



Source: OPEGA graphic created based on information provided by DHHS.

August 2010 - March 2011

MIHMS Project Staff Originally Identified the Issue in 2010 but Other Concerns Took Priority

Many MIHMS Issues Occurred Following Go-Live

The expedited MIHMS timeline did not allow for resolution prior to go-live of some system issues identified during testing.

DHHS chose to have an extremely short development, design, and implementation period to allow for quick deployment of the MIHMS system. The federal Centers for Medicare and Medicaid Services (CMS) approved this timeline to allow DHHS to quickly create a new system due to issues with the prior system, MECMS. This ultimately did not allow time for resolution of some system issues identified during testing. System testing conducted from June to August 2010 revealed errors in eligibility information coming into MIHMS. DHHS staff told OPEGA these errors were not considered significant enough to delay go-live. However, IV&V contractor BerryDunn recommended delaying go-live to allow time for further testing. They documented a number of issues, including those related to eligibility, which they believed warranted further testing before the system was deployed.

[6] DHHS told OPEGA it is a MaineCare policy decision to pay providers for periods during which MaineCare members are technically ineligible, but their eligibility status has not yet been updated in MIHMS.

DHHS staff told OPEGA the decision to proceed with MIHMS go-live was made, in part, due to intense pressure from the Administration and federal CMS because of the extensive problems with MECMS. Therefore, they moved ahead with the September 1 go-live date despite BerryDunn's recommendation to the contrary. OPEGA observes that in the wake of MECMS, DHHS had to balance the need to quickly deploy an improved MaineCare claims processing system with adequately addressing system issues to limit risk.

Immediately following go-live, many issues occurred with MIHMS. The system had problems correctly identifying members as eligible, which necessitated bridge payments (or interim payments) made directly to providers because the system could not process claims properly. DHHS staff told OPEGA that MIHMS was not properly paying claims for 100,000 eligible MaineCare members following go-live.

Following MIHMS go-live, many system issues arose and the DHHS MIHMS project team faced significant staff turnover.

During this same time period, in fall 2010, the MIHMS project team faced significant staff turnover. Several MIHMS team members left DHHS to work at Molina, and in October, six weeks after go live, the DHHS MIHMS Project Manager resigned. The Director of Change and Data Management served as interim DHHS MIHMS Project Manager until a new project manager was put in place in early 2011.

Molina Struggled to Address MIHMS Issues; DHHS Did Not Have Effective Means for Prioritizing Them

DHHS staff told OPEGA that Molina struggled to address the large number of issues following go-live, and did not have the capacity to fix them in a timely manner. As additional system defects were identified, older defects remained unresolved. Requests to resolve issues made by the Change Management Team aged. DHHS and Molina worked to identify errors that needed resolution in order for the system to obtain certification from federal CMS and to address other priorities including successfully paying providers, updating the system to meet HIPAA requirements, and ensuring claims were paid for eligible members.

OPEGA found DHHS was not executing project procedures as designed to prioritize and escalate MIHMS issues.

Issues important to MIHMS certification were placed on what was known as the Stabilization List. This list essentially prioritized fixing those issues. However, the MIHMS project team had no effective method in place for prioritizing which issues on the Stabilization List were most important. Instead, this was left up to Molina. OPEGA found that DHHS was not executing project procedures as designed in the MIHMS Project Change Management Plan, which governs who on the Project Team should review, escalate, and monitor MIHMS issues.

OPEGA spoke with federal CMS and IV&V contractor BerryDunn about the issues that occurred following go-live. CMS said they had not been concerned by them because problems are typical of any system start-up. BerryDunn said compared to what other states had experienced in implementing their Medicaid management information systems, the MIHMS implementation was completed relatively quickly and smoothly.

DHHS Staff Identified the Ineligible Segments Issue in April 2010

MIHMS project staff originally identified the issue in April 2010, and requested it be corrected in August 2010.

In April 2010, the DHHS MaineCare Subject Matter Expert (SME) for eligibility identified that, due to a mistake in the way the MaineCare eligibility rules were written for MIHMS, MIHMS would not properly close eligibility for members who became ineligible in certain instances. Therefore, certain eligibility end dates entered correctly into ACES could not be correctly interpreted by MIHMS, essentially leaving eligibility open indefinitely for some members although they were no longer eligible for MaineCare. He believed, however, that the number of affected records would be small and could be fixed manually.

During system testing one month prior to go-live, DHHS identified that for unknown reasons the number of affected records was much greater in magnitude than expected, and staff would be unable to keep up with the volume. On August 31, 2010, the day before go-live, MIHMS project staff submitted a CR for a fix to what became known as "the ineligible segments issue". This CR requested a "work-around" to correct the eligibility discrepancies.[7] Following go-live, the problem was exacerbated by data transfer delays from the Data Hub to MIHMS, which caused a further increase in the number of affected records.

MIHMS Project Management Became Aware the Issue was Causing Claims to be Paid in Error by March 2011

MIHMS project management was aware by at least March 2011 that the issue was causing claims to be paid in error, but the extent of the impact could not easily be quantified.

OPEGA reviewed emails from March 2011 which showed the SME tried to raise the priority of the ineligible segments issue and have it placed on the Stabilization List because it had not been addressed. He communicated to MIHMS project management that the ineligible segments issue affected over 23,000 members and was causing claims to be paid in error. However, he could not easily quantify the number of claims or the financial impact of the issue. This was in part due to the fact that not all ineligible segments were an indication of an ineligible member. A member may be eligible for MaineCare under multiple categories, and even if his/her eligibility had not properly ended in one category, the individual may still be eligible under another category. The PCCB discussed the issue in May 2011 and placed it on the MIHMS Stabilization List, a list of items important to MIHMS certification, to be addressed by Molina.

Although project management was aware of the issue at this point, DHHS staff told OPEGA the possible extent of the issue's impact was not readily apparent. DHHS was unable to easily identify the number of ineligible clients receiving benefits or the resulting financial impact, and did not devote resources to determining this due to a multitude of competing issues. Therefore, the issue was not prioritized further or escalated to the Steering Committee for discussion, and DHHS did not monitor the number of affected members.

[7] A separate change request was later submitted for the more complex and time consuming MIHMS fix to the issue which would prevent ineligible segments from being created altogether.

Indications of the Issue's Impact Began to Surface in Mid-2011 as It Remained Unaddressed

Contractor was Unable to Fix Issue in a Timely Manner

Molina struggled to address a multitude of issues after go-live and was unable to implement a timely fix to the ineligible segments issue.

Molina struggled to implement a fix for the ineligible segments issue following the identification of the issue and its placement on the Stabilization List. After an extended wait time for the contractor to take action on the original CR, which was created in August 2010, project management approved a new CR in May 2011 which included OIT assistance to address the issue. Testing of this fix did not begin until August 2011 and the fix remained in the test environment until December 2011. DHHS staff told OPEGA that fixing this problem was more difficult and time consuming than initially anticipated. In addition, Molina's capacity to work on the fix was limited due to the number of other CRs and TRs that still needed to be addressed.

DHHS staff told OPEGA that Molina was tasked with creating a plan to address a multitude of post-go-live issues, but struggled to complete this plan. As a result, DHHS suspended all contract payments to Molina for several months during 2011. DHHS staff told OPEGA this was meant to pressure the contractor to complete steps toward system certification. DHHS' monthly written reports to the Legislature reviewed by OPEGA did not contain discussion of these concerns with contractor performance, but according to DHHS and OFPR staff, the Commissioner provided this information to the Legislature verbally.

DHHS Experienced Caseload Issues, but Did Not Link Them to Ineligible Segments

Concurrently, DHHS began experiencing inconsistencies in the MaineCare caseload data. DHHS decommissioned the prior MaineCare caseload data system, WELFRE, in June 2011 and transitioned to using MIHMS data produced by the Decision Support System (DSS). When this transition was made, the MIHMS data showed a noticeable change in MaineCare caseload when compared to the prior month's data from WELFRE. OMS Finance staff worked with staff on the MIHMS project team to identify the cause of these inconsistencies, and determined that MIHMS was counting members who were eligible in multiple Recipient Aid Categories (RACs) differently than WELFRE. OMS Finance focused on resolving this problem in the data, but did not link the inconsistencies to the ineligible segments issue. DHHS told OPEGA that the real-time reports they were seeing from DSS further added to their confusion over what was driving the data inconsistencies they were seeing.[8]

As OMS Finance worked to correct the caseload data issues, the Commissioner of DHHS presented updated caseload data to the Committee on Appropriations and Financial Affairs (AFA) throughout the summer and fall of 2011. The

[8] DSS continuously updates MaineCare caseload data. Previously DHHS had relied on printed reports from WELFRE which gave a snapshot of the data at a point in time. For example, when eligibility changes occur after data is produced for a given month, DSS will update the data for previous months in future caseload reports, whereas WELFRE reports were not updated.

Commissioner reported that minor differences in caseload were resulting from how the two systems, WELFRE and MIHMS, assigned individuals eligible for multiple benefits to a category, and the Department was working to fix this.

Inconsistencies in the MaineCare data emerged but DHHS did not connect them to the ineligible segments issue.

The Commissioner told OPEGA that she accepted the explanation her staff provided for the changes in caseload, and did not have reason to question it. The Director of OMS Finance told OPEGA he thought his department had resolved the caseload data issues and was confident the caseload data from MIHMS was accurate as of September 2011.

Extent of Increases in Caseload Figures Not Apparent in Data DHHS Presented to Legislature

Over time, MaineCare caseload numbers increased as DHHS worked to resolve inconsistencies in the caseload data. These inconsistencies were the first outwardly noticeable impact of the ineligible segments issue that may have come to the attention of the Legislature through the monthly caseload reports DHHS provided. During this period, OFPR had concerns about the data and was questioning DHHS about the cause of the inconsistencies. However, the Commissioner told OPEGA that the AFA Committee itself did not ask many questions about the caseload data, unless it pertained to a particular member category, such as childless adults. OPEGA believes this was due in part to the explanations DHHS provided for the inconsistencies in caseload data and in part to the manner in which DHHS presented the caseload data to the Legislature during this time period.

The MaineCare caseload data DHHS provided to the Legislature somewhat masked the extent of the inconsistencies.

OPEGA's review of the data DHHS provided to the Legislature showed that the several adjustments DHHS made to the caseload data somewhat masked the extent to which overall caseload numbers were increasing. For example, an increase in a particular month (e.g., June 2011) would not be evident unless the revised caseload reports were compared side by side (e.g., August 2011 and September 2011). The caseload reports had also changed in this time period to include additional data on non-MaineCare Low Cost Drugs for the Elderly and Disabled Program (DEL) and MaineRx Prescription Drug Program members as requested by AFA, which further confused comparisons between data DHHS reported in different months. During this period OFPR was tracking the caseload changes that occurred and reporting them in its monthly *Fiscal News*.

OPEGA observed that the various explanations provided by DHHS for the inconsistencies in the data did not lead the Commissioner or the Legislature to question the data further, but emails OPEGA reviewed showed OFPR had expressed concerns. OFPR, however, does not have any means to independently verify MaineCare caseload data, and had only the explanations provided by DHHS to rely on. DHHS told OPEGA that once they made adjustments to the MIHMS data, they believed the numbers were accurate.

DHHS Executive Management Did Not Know of the Issue until Late 2011

Several Events in Late 2011 Ultimately Brought the Ineligible Segments Issue to Executive Management's Attention

In late 2011, several events occurred that ultimately brought the ineligible segments issue to the attention of DHHS executive management:

Executive management became aware of the issue in late 2011 after other agencies outside OMS began asking questions.

- The Executive Director of the Maine Health Data Organization (MHDO) directly contacted the Commissioner of DHHS on November 28, 2011 with questions about inconsistencies between MHDO's data and DHHS' reported MaineCare caseload numbers. He expressed concerns about the caseload data reliability and a possible link to the shortfall in the MaineCare budget the Commissioner had publicly reported. The Commissioner followed up with her staff to inquire about the possible causes of the inconsistencies. OPEGA reviewed email communications among DHHS management, including the Commissioner, during this time period. By early December, these communications show the Commissioner was asking questions and becoming increasingly concerned about the caseload data. These communications showed DHHS staff was attempting to identify the source of the issues with the caseload data in late December 2011, and determined they were the result of the ineligible segments issue in January 2012.

- In December 2011, The Office of Family Independence (OFI) communicated to DHHS management that they had not realized an expected cost savings of $4 million although they improved the timeliness of their disability claims processing to within 45 days as planned. After reviewing the data further, OFI found that MIHMS was showing individuals eligible for temporary coverage that were no longer shown as eligible in ACES. On December 15, 2011, OFI communicated to OMS staff that based on discussions with the MIHMS project team, they believed this was caused by the ineligible segments issue. Based on email communications OPEGA reviewed, this was communicated to the Commissioner by January 9, 2012.

- In May 2011, the State Auditor's Office had begun its annual Single Audit, which included both the Medicaid and CHIP programs. That month, as part of their initial inquiries related to internal control, the auditors requested a reconciliation between ACES and MIHMS. The reconciliation showed discrepancies in the number of eligible individuals between the two systems which were not being addressed. During the testing phase of the audit conducted in October 2011, the Auditor's Office found a payment error rate of 1.67 percent in sample of 240 claims payments.[9] At that point, they began to question DHHS about the cause of the claims payments for ineligible individuals. DHHS communicated to the Auditor's Office in late

[9] These two issues were included in a finding in the State Auditor's Single Audit Report for SFY 2011, which was released on March 30, 2012.

December 2011 that they had identified the errors as resulting from the ineligible segments issue.

DHHS Reported SFY12 Budget Shortfall to the Legislature in Late 2011

During the same time period, DHHS reported a $121 million SFY12 budgetary shortfall for MaineCare and the Legislature considered proposed cuts.

In November 2011, the Commissioner of DHHS reported an estimated MaineCare shortfall of $70 million to the AFA Committee leadership. Later that month, DHHS revised this figure to an estimated $121 million. Throughout December 2011 and into January 2012, the Commissioner presented information at Committee meetings on the causes of the shortfall, and responded to the Committee's questions. The Committee considered proposed cuts to offset the shortfall and heard extensive public testimony on the potential impacts of these cuts.

OPEGA believes it would have been reasonable during this time period for DHHS to question the potential impact inconsistencies in the caseload data may have had on the shortfall projections. However, the Director of OMS Finance told OPEGA that DHHS believed the data was accurate at the time the budget shortfall estimates were being developed. OPEGA observes that at that point, the Commissioner had limited information about the extent of the issue's impact. Emails OPEGA reviewed showed the Commissioner was asking her staff for this information.

January - April 2012

DHHS Did Not Have Estimates of the Financial and Caseload Impact of the Issue until Early 2012

Caseload and Financial Impacts of the Issue were Estimated in January and February 2012, Respectively

In late January 2012, DHHS staff estimated a caseload impact of 19,000 members resulting from the ineligible segments issue, but told the Commissioner this estimate was still tentative. Emails OPEGA reviewed indicated the Commissioner asked staff to delay the regular monthly reporting of caseload figures to OFPR and the Legislature. The Commissioner told OPEGA this was because she was not confident in the data's accuracy. OPEGA reviewed email communications for January-February 2012 which show the Commissioner continued to ask questions about the issue's impact and express concerns about the accuracy of the data. Based on these communications, it was apparent to OPEGA that the Commissioner expected further information but it was not available.

MIHMS project staff estimated the issue's caseload and financial impact in early 2012, but the Commissioner lacked confidence in this information.

On February 10, 2012, DHHS staff estimated the maximum financial impact of the issue to be $28 million. Email evidence and interviews with DHHS staff indicate that the financial data was a ballpark estimate at this point. According to the Commissioner, she did not present this number to the Legislature because she was not confident it was accurate.

Information on the Ineligible Segments Issue was Reported to the Governor's Office in Late February 2012, and to the Legislature One Week Later

The Commissioner reported information on the ineligible segments issue and the resulting 19,000 member caseload impact to the Governor's office on February 28, 2012 and to the Legislature in early March 2012. DHHS project staff told OPEGA that due to a multitude of competing priorities, resources were not devoted to determining the financial impact of the ineligible segments issue prior to January 2012. Consequently, DHHS had not been monitoring the impact of the issue and had limited knowledge of its financial impact.

OPEGA found no indication that the Governor's office was aware of the ineligible segments issue prior to February 28, 2012. The Commissioner of DHHS, as well as the Governor's Office, told OPEGA that after the Commissioner informed the Governor of the issue, he instructed her to inform the Legislature. The Governor's Office told OPEGA they immediately informed Legislative leadership after finding out about the issue. The Governor held a meeting on March 2 with DHHS staff, the State Chief Information Officer (CIO), State Controller, and MIHMS contractors to obtain further information on the issue and express his concern over possible communication silos.

DHHS notified the Governor's Office of the issue on February 28, 2012, and the Legislature about one week later.

On March 9, 2012, DHHS reported the ineligible segments issue and the resulting caseload impact to the Legislature. The Commissioner told the Legislature that DHHS was working to quantify the financial impact of the issue at that time. On April 27, 2012, DHHS told AFA the estimated impact of the ineligible payments from September 1, 2010 to December 28, 2011 was $10.7 million[10]. The OMS Finance Director and the State Controller told OPEGA that determining an accurate number was difficult and time consuming.

DHHS is still working to identify the financial impact of the issue on claims paid in 2012, but expects this will be limited because the Data Hub fix to the ineligible segments issue was successfully implemented in March 2012. As of November 2012, the fix to the ineligible segments issue within MIHMS itself has not yet been implemented by Molina.

Uncertainty over Possible Impact of the Issue Led DHHS to Delay Providing Information to the Legislature

In December 2011 and January 2012, DHHS was addressing questions from the Legislature about the shortfall in the MaineCare budget. OFPR reported they were unable to independently verify the budget numbers reported by DHHS. OPEGA questioned DHHS staff about whether they had concerns with the accuracy of the budget shortfall estimate as issues with the caseload data came to light. One DHHS manager told OPEGA that the budget estimates had already been presented to the

[10] The state share of these payments amounted to approximately $6.8 million, with the remainder—approximately $3.8 million—paid by the federal government. As of November 2012, DHHS does not know what portion, if any, of the federal funding will have to be repaid. DHHS made the policy decision not to recoup the improper payments from providers.

Legislature at this point, indicating they could not be revised because they were already "out there."

OPEGA observed that a prior change to the DHHS shortfall estimate (from approximately $70 million to $121 million), coupled with the intense scrutiny surrounding the budget shortfall estimate and controversial nature of the proposed MaineCare cuts, created an environment that was not conducive to a DHHS admission of uncertainty. Although DHHS could have reported the existence of the issue to the Legislature in January 2012, DHHS would have been able to provide only limited useful context related to its possible impact. DHHS told OPEGA they felt this information was not actionable at that time.

The Commissioner of DHHS told OPEGA that uncertainty over the magnitude of the issue's impact led her to delay providing information to the Legislature.

OPEGA questioned the Commissioner of DHHS about her philosophy and approach to providing information to the Legislature. The Commissioner told OPEGA she is committed to providing comprehensive, credible, accurate reports to the Legislature. She said DHHS is working to provide more meaningful, relevant information to AFA, and they are thinking about what information the Committee needs.

Issues Noted

During the course of the review, OPEGA identified issues that we believe contributed to the ineligible segments issue not being prioritized higher or reported to the Commissioner earlier. OPEGA did not gather sufficient information to make specific recommendations related to these issues because this was beyond the scope of our review. However, we noted the following issues which we believe are concerning and warrant DHHS and OIT consideration regarding MIHMS and future system projects. We are aware that these agencies had begun taking steps to address these issues even prior to the commencement of our review.

OPEGA noted MIHMS project management and governance issues during the course of our work, but did not gather sufficient information to make specific recommendations.

- **MIHMS Project Management.** During the course of this review, OPEGA noted apparent issues with MIHMS project management. OPEGA was unable to clearly identify who was responsible for guiding and escalating project decisions and issues. Although under the MIHMS Project Change Management Plan these duties fall to the DHHS MIHMS Project Manager, it appears she deferred to Molina, allowing the contractor to guide the Project Change Control Board process. The Commissioner told OPEGA that DHHS has taken steps to improve project governance. New staff has been put in place, including new State and Molina project managers.

- **Steering Committee Effectiveness.** According to DHHS, the Steering Committee did not function properly during the time period discussed in this report. The Commissioner of DHHS said problems with contractor Molina contributed to this. It was unclear to OPEGA how the Steering Committee functioned or who guided what it considered and discussed. DHHS told OPEGA the Steering Committee has changed as the project evolved from development, design, and implementation into system steady

state. During DDI, the contractors guided the Steering Committee, but now this responsibility has shifted to the State.

DHHS does not currently have guidance in place directing the work of the Steering Committee or outlining its goals. It appears to OPEGA that DHHS was not able to use the Committee as an effective tool to help manage project risk; however, this review did not include a detailed assessment of the Committee's work. The Molina project manager has been replaced, and the OMS Director has been appointed to lead the Steering Committee.

- **Issue Prioritization.** Despite the existence of the Stabilization List and the procedures in the MIHMS Project Change Management Plan, DHHS staff told OPEGA there was no effective method in place for prioritizing change requests. OPEGA found that DHHS was not executing project procedures as designed in the MIHMS Project Change Management Plan, which governs who on the Project Team should review, escalate, and monitor MIHMS issues. In the case of the ineligible segments issue, it appears project management did not fully understand the problem and its potential implications, and therefore did not prioritize or escalate it further up the chain of command in accordance with these procedures. DHHS told OPEGA they have since put measures in place to prioritize MIHMS issues based on fiscal impact and other specific criteria.

- **Communication within the MIHMS Project Team, and between the MIHMS Project Team and Executive Management.** OPEGA observed that there appear to be communication issues both within the MIHMS Project Team and between the MIHMS Project Team and executive management. As shown in Figure 2 on page 8, there are several layers of management between the DHHS MIHMS Project Manager and the Commissioner. Although DHHS does have a Project Change Management Plan which outlines procedures for how the Project Team should review and escalate MIHMS issues, and the Commissioner or a representative sits on the Steering Committee, the ineligible segments issue did not reach the Commissioner until it had an obvious impact. As a result, the Commissioner was unable to present accurate and timely information on the issue to the Legislature. The fact that the DHHS MIHMS Project Manager did not escalate this issue to the Steering Committee may have resulted from a number of factors, including turnover within the position and the large number of other issues that surfaced after go-live. OPEGA noted that at the time of this review, project and executive management still did not seem to have a clear understanding that Molina has not yet fixed this issue within MIHMS itself, and is still responsible for doing so.

  The Commissioner told OPEGA that DHHS is changing its organizational culture to create an atmosphere of healthy communications and transparency. The Commissioner said issues from the merger of Maine's Department of Behavioral and Developmental Services (BDS) and DHHS linger and impede good communication. She told OPEGA the Department's Division of Audit is spearheading initiatives in Compliance and Risk Assessment on how to assess and address issues. Procedure

manuals are in development to ensure institutional knowledge is retained when staff turnover occurs. DHHS also told OPEGA they have created a MIHMS Executive Management Team, reformed the Steering Committee, and are holding Monthly Audit and Risk Management meetings. For further details, please see the agency response letter.

Agency Response

In accordance with 3 MRSA §996, OPEGA provided DHHS an opportunity to submit additional comments on the draft of this report. The response letter from DHHS can be found at the end of this report.

OPEGA discussed the preceding issues with DHHS management. DHHS is taking several actions as a result of the ineligible segments issue in an effort to address these issues, which are detailed in the agency's response letter. OPEGA has not assessed the adequacy of these actions; however, we believe they are positive steps toward addressing the issues noted.

Acknowledgements

OPEGA would like to thank the management and staff of DHHS and DAFS, as well as the Governor's Office for their cooperation during this review. We would also like to thank the management and staff in the State Auditor's Office, the State Controller's Office, the Legislature's Office of Fiscal and Program Review, and the Legislature's Office of Policy and Legal Analysis for their assistance in providing information.

Appendix A. Scope and Methods

The scope for this review, as approved by the Government Oversight Committee, included three specific questions. OPEGA conducted the following work to address those questions.

Interviews with staff and management at:

- Department of Health and Human Services, including individuals within the Office of MaineCare Services and members of the MIHMS project team
- Department of Administrative and Financial Services, including individuals within the Office of Information Technology
- Office of the Governor
- State Auditor's Office
- State Controller's Office
- The Legislature's Office of Fiscal and Program Review and Office of Policy and Legal Analysis
- Federal Centers for Medicare and Medicaid Services
- Independent Verification and Validation contractor BerryDunn

A review of documents including:

- DHHS reports provided to the Joint Standing Committees on Administrative and Financial Services and Health and Human Services
- MIHMS project plans and documentation, including the MIHMS Change Management Plan and change request (CR) documentation
- MIHMS Steering Committee minutes
- Emails provided by DHHS to the Lewiston Sun Journal in response to a Freedom of Access Act request[11]
- Email communications between DHHS and the Office of Fiscal and Program Review
- The Office of Fiscal and Program Review's monthly *Fiscal News*
- Relevant work papers from the State Controller's Office and State Auditor's Office
- Independent Verification and Validation reports
- Federal Centers for Medicare and Medicaid Services guidance and requirements

[11] OPEGA limited review to emails provided to us by DHHS rather than directly querying the State's email system. Due to time and resource constraints, OPEGA was unable to sort through all of DHHS management's emails for this period. We judged those provided to us by DHHS sufficient to give an accurate picture of events during this time period based on our corroboration of these events with other sources, including email communications provided by OFPR and interviews with staff.

Appendix B. Timelines

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Timeline 1: Events March – August 2011

Prior Events

Prior to Go-Live.....Independent contractor monitoring the project (BerryDunn) recommends delaying MIHMS go-live to allow further time for system testing, including eligibility interfaces. BerryDunn identifies risk of improper payments or failure to pay providers resulting from MIHMS/Data Hub interface issues.

April 2010.....SME on MIHMS project team identifies ineligible segments issue but believes records can be fixed manually.

August 2010..... During system testing, SME learns the number of ineligible segments is much greater than anticipated and on August 31 submits original CR to create a fix for the issue.

September 1, 2010..... MIHMS goes live.

Following Go-Live..... Many system issues occur; some expected, others not. MIHMS Project Manager resigns abruptly in October 2010 and interim Manager is put in place.

DHHS Actions & Knowledge of Issue

March 2011
SME expresses concern to project management that ineligible segments issue documented in August 2010 is still not addressed. He states over 23,000 members are affected, and claims are being paid in error for some of those individuals, although he is unable to estimate the magnitude.

May 2011
After extended wait for Molina to work on original CR, project management approves replacing it with a new CR that includes State OIT assistance to create a Data Hub fix for the ineligible segments issue. Issue is placed on the Stabilization List.

August 2011
DHHS and Molina begin testing the new Data Hub fix for the ineligible segments issue.

Information Reported to Legislature

August 1, 2011
AFA receives MaineCare caseload report through June 2011. The June data is from MIHMS and prior months from WELFRE. DHHS reports the minor changes in caseload from May to June may be due to differences in how WELFRE and MIHMS count members eligible in multiple benefit categories.

August 30, 2011
AFA is told DHHS is working to resolve issues with financial eligibility information coming into MIHMS from ACES. AFA is also told caseload data is being reviewed and adjusted for potential inconsistencies between WELFRE and MIHMS.

Other Events

March 2011
New Project Manager assigned to MIHMS team.

May 10, 2011
The State Auditor receives DHHS' reconciliation report for ACES and MIHMS, which shows a discrepancy in the number of eligible clients between the two systems.

May 2011
State Auditor's office begins annual Single Audit, which includes Medicaid and CHIP.

May 2011
Governor meets with providers and MIHMS project team about issues with provider payments.

June 2011
DHHS stops using data from WELFRE for monthly MaineCare caseload reports; from June on, caseload data comes from MIHMS. OMS Finance staff notice inconsistencies in caseload between WELFRE and MIHMS. They believe this is due to how MIHMS counts members eligible in multiple benefit categories. They begin trying to resolve the differences.

Source: OPEGA graphic based on information obtained during field work.
Note: See beginning of report for list of acronyms.

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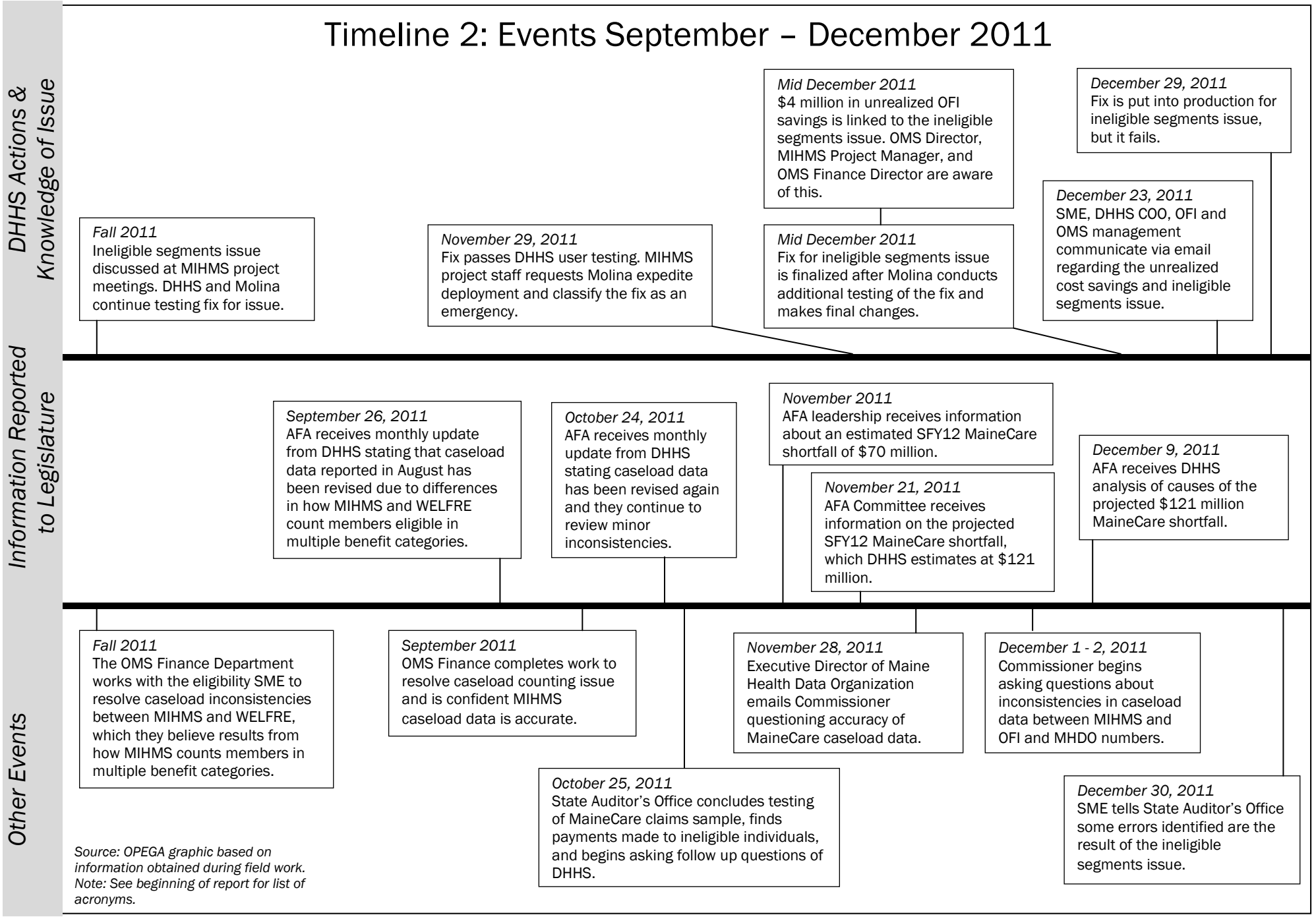
Timeline 2: Events September – December 2011



Source: OPEGA graphic based on information obtained during field work.
Note: See beginning of report for list of acronyms.

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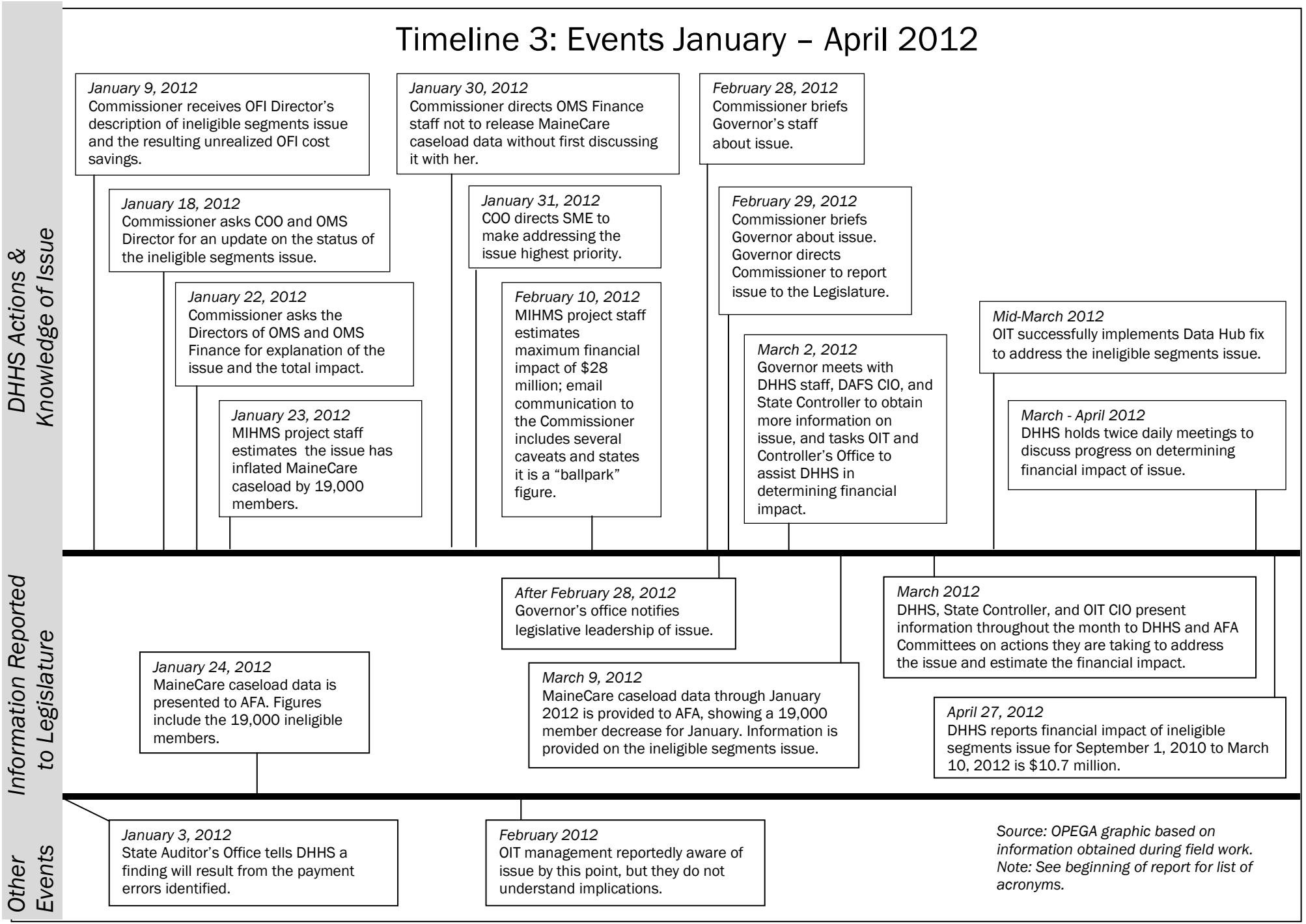
Timeline 3: Events January – April 2012



Source: OPEGA graphic based on information obtained during field work.
Note: See beginning of report for list of acronyms.

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Department of Health and Human Services
Making People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

November 7, 2012

Beth Ashcroft, Director
Office of Program Evaluation and Government Accountability
#82 State House Station
Cross Office Building
Augusta, ME 04333-0082

Dear Ms. Ashcroft:

The Department of Health and Human Services appreciates the time and effort the Office of Program Evaluation and Government Accountability dedicated to investigating this complicated issue. We are confident OPEGA and the Legislature found the Department responsive and helpful throughout this review. Quantifying the financial, member, and provider impact of the ineligible segments involved many Offices and Departments, several vendors, and was the result of six weeks of twice daily "war room" meetings.

As you note in your report, it is important to remember the massive amount of change occurring in the claims management system during the cited period. By January 2012, DHHS and their vendor had closed more than 1,000 change orders and trouble tickets and still faced a backlog of more than 571 requests. It is in this context that you examined the events.

The combined support provided by the Office of the State Controller, the Office of Information Technology and the Service Center was invaluable to DHHS. Further, I am gratified to see your work recognizes the Department's immense effort in quantifying information that is ***accurate*** and ***actionable***. I would like to highlight just a few of the changes that have occurred since January 2012:

MIHMS Change Management Governance – The Department has instituted practices for change management that did not exist immediately after go- live. It has provided pathways for subject matter experts to escalate issues and concerns and improved communications across areas affecting MaineCare claims by forming standing work groups with clear direction. We are now measuring the potential fiscal, member and provider impact to claims systems changes. To further ensure consistent governance across all Offices, the Department has hired a Director of Business Technology Solutions.

MIHMS Executive Team – The Department has instituted biweekly meetings with leaders from various MaineCare claims system stakeholders. These Executive Team meetings are an opportunity to discuss governance, potential and current policy changes, strategy, operational needs, and personnel concerns. The group consists of the DHHS Commissioner, MaineCare Director, MIHMS Project Manager, State CIO, State Controller, Director of Business Technology Solutions, Chief Operating Officer, and the

Molina Project Manager. These meetings provide yet another avenue for concerns to be elevated and acted upon.

Release Management – Until recently, the MIHMS was releasing new code into production three times a week which, by most standards, is too often to be considered stable. Changes to the claims system are now being implemented every seven days and the Department has set a goal of monthly releases by August 2013. A planned release allows time for more extensive impact assessments, approval by the Steering Committee and more structured project management.

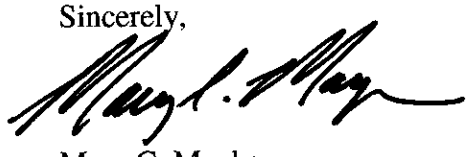
Eligibility Governance – Both policy and technical change to eligibility systems as well as upstream and downstream effects are now being coordinated through an Eligibility Work Group. This bi-weekly forum involves program managers from MaineCare (OMS), the Office of Child and Family Services (OCFS), the Office for Family Independence (OFI), the Financial Service Center, the Office of the Commissioner, and the Office of Information Technology (OIT).

Strong Project Management – The Department and its vendor, Molina, have brought additional project management resources to their respective teams in a successful move to stabilize the MaineCare claims systems. The years of industry experience brought to the project since April is apparent in the improved structure and communications that is now occurring. Through a more controlled resource planning and project management technique called Agile, the Department and Molina are better able to define claims systems change requirements, assign resources and detect defects earlier.

Risk Management Committees and Monthly Audit Meetings – The Department has established Office-level risk management committees that report monthly to the Commissioner through the Division of Audit. This provides yet another pathway by which various people throughout the organization may escalate concerns to Senior Management.

While we believe much work still remains ahead of us, all parties are confident that our governance, communications and the process by which we do our work has greatly improved. As it has been said since the early days of ineligible segments, the relationships that have been built and the team approach to our work is something that has served us well and will continue to serve us well in the future.

Sincerely,



Mary C. Mayhew
Commissioner

MCM/klv