Medicaid Recovery Audit Contractor (RAC)

HMS performs various program integrity recoveries on Medicaid paid claims on behalf of the New York State Office of the Medicaid Inspector General (OMIG) including the following:

- *Maximize Medicaid dollars recovered and enhance program integrity by supplementing OMIG's current program integrity efforts.*
- *Conduct automated payment integrity reviews of provider patient or financial accounts to identify and recover overpayments.*
- *Analyze New York Medicaid paid claims to identify potential overpayments and verify findings through payment integrity reviews.*
- *Prompt providers to review their patient and financial accounts and identified and return Medicaid overpayments.*
- *Manage a Web-based portal for facilitating, tracking, and reporting provider self-disclosures*
- *Conduct data matches with third-party payers, including private insurers and Medicare, to verify Medicaid payments; identify and recover payments in excess of Medicaid's true liability as a secondary payer.*
- *Initiate recovery of claims where overpayments are identified.*
- *Submit detailed reports and conduct all status meetings in order to meet OMIG's reporting requirement.*
- *Refer suspected fraud to OMIG for investigation*

A. Contract Background and Description

Under the Medicaid Match and Recovery Project, OMIG contracts with HMS to perform Pre-Payment Insurance Verification (PPIV) updates, as well as third-party liability, payment integrity, and trauma recoveries. The current contract, initiated in January 2009, runs through December 2014, and includes an optional one-year renewal. Fees on recoveries are paid solely on a contingency basis, with a 5.25 percent fee for all recoveries up to $125 million in a calendar year, with recovery activity beyond $125 million subject to the contingency fee percentage plus 1.5 percent.

Payment Integrity initiatives are a key focus of the Medicaid Match and Recovery Contract. These start with analyses that utilize wide-ranging data from analytical paid claims to providers'

patient accounting records. In cases where the analysis suggests that Medicaid may have overpaid in a certain situation, HMS initiates the review process with OMIG's approval. Depending on the outcome of the review, the vendor may initiate the recovery process. All reviews and recoveries are performed at the claim level.

Background

Medicaid programs occasionally pay beyond their true liability for various reasons that range from the inherent asymmetry of information to policy oversights. OMIG, through the Department of Health (DOH), supplies most of the data that is used for the analysis electronically to HMS via secured FTP connection on a periodic basis.

On behalf of OMIG, HMS continuously performs data analysis to identify such situations and recovers funds that were allocated inappropriately. In addition, HMS will seek data from external entities such as insurance carriers and health care providers that possess information that could be decisive in determining Medicaid's true liability. With acquired data, the contractor performs each analysis within the general third-party liability framework, as well as New York-specific payment integrity guidelines.

Overview of Our Approach

The process for payment integrity initiatives varies according to the provider type as well as claim type being reviewed. The following describes the payment integrity review processes, provider self-disclosure, and data mining initiatives that OMIG and HMS have developed to enhance identification and recovery of Medicaid overpayments. We have included current initiatives and those under development, as well as potential areas of interest (e.g., some that would require coordination with other state agencies).

B. Automated Reviews

B.1. Payment Integrity Reviews

The objective of payment integrity reviews is to identify overpayments made to providers through claim level analyses of patient accounts. Using techniques that comply with New York State provider agreements, HMS will pursue each possible type of overpayment.

B.1.a. Onsite and Desk Reviews - Process Overview

Initial Contact and Data Request

An initial contact is made by mailing a letter and data requests to the patient accounts manager approximately 15 days prior to the review. The data request is used to determine the scope of the onsite review, address logistical considerations, respond to preliminary questions, and provide a general overview of the credit balance processes to the provider. The notification letter provides information regarding the review such as:

- Introduction to HMS
- Contractual relationship between New York State and HMS
- Expectations of the provider
- Reason for the review
- Request for preview documentation
- HMS contact for questions

Shortly after sending the initial mailing, HMS will request specific documents that allow for an efficient review to be performed. The pre-review documents include:

- Detailed listing of credit balances with Medicaid activity
- Accounting system information

The credit balance review program may rely upon the following approaches:

- **Desk reviews**, which are conducted at an HMS office using provider documentation, such as patient accounting reports, system screen shots (e.g., demographics, payments/adjustments, summary of charges, and relevant notes), and copies of RAs, explanation of benefits (EOBs) forms, and adjustment forms.
- **Onsite reviews**, for which providers are selected based upon criteria developed by NYS and HMS's review team. Designated criteria can include provider size, location, number of Medicaid paid claims, billing activity, past findings, etc. The review consists primarily of provider personnel inquiries, followed by an analytical review of transactions affecting the financial accounts of selected Medicaid members. HMS also conducts reviews of all facilities periodically – regardless of billing history.

Review Preparation and Account Selection

HMS staff reviews the documentation that is sent over by providers to reconcile Medicaid credit balances to aged credit balance summary. Staff will trace credit balances from the oldest FYE data provided to the most current. If significant changes in the number and/or dollar amount of credit balances are identified, staff reviews the appropriate financial records and interviews key provider staff to understand the underlying reason for the change.

Accounts are then selected for the desk or onsite review. Contractor will review accounts identified as having outstanding or closed credit balances. Often, the credit balance report is sorted in order to work the higher credit balances first, along with other accounts that may have an identifiable credit balance amounts

Additionally, the vendor utilizes the Medicaid paid claims file to perform analysis and produce provider-specific claims listing in advance of an onsite review. HMS will target claims that have characteristics associated with overpayments (e.g., identified TPL but no TPL payment, low TPL payment, TPL denial, etc.).

Onsite Reviews

Entrance Conference

HMS conducts an entrance conference in order to describe the purpose of review to the patient accounts manager/controller. During this meeting, the review team is introduced and the general process for the review is discussed. They will also seek to obtain an understanding of how the provider processes credit balances.

An entrance conference generally covers the following key topics:

- Information on the necessary steps for the review of Medicaid accounts. For all accounts that are reviewed, HMS will print screen shots and obtain any necessary RAs or EOBs, work the accounts, and submit to the provider representative for approval.
- In some cases, a request for an updated credit balance report once onsite. HMS will also request usernames and passwords in order to access the patient financial accounting systems.
- An explanation of any unusual billing/reimbursement practices.
- Identification of a technical resource that has the authority to sign off on account findings and resolve account posting questions. Usually, this individual is the provider's refunds supervisor.
- Explanation of the fact that a brief exit conference will be held at the end of the review to discuss findings and address any concerns the provider may have.

Provider Data and Records Assessment

At the beginning of an onsite credit balance review, staff will review the provider data and records according to the following processes.

- Review A/R reconciliation to the G/L to ensure the entire credit balance population has been identified. This ensures that the review encompasses all known credit balances.

- Review the reconciliation of all cash clearing accounts in order to verify that all deposits are reversed and applied to individual patient accounts. Any carryover balances should be explained. Medicaid payments greater than 30 days old will be noted, and HMS will request that the money be refunded back to Medicaid if a disposition cannot be identified.

- Review cash posting accuracy to ensure payments are being applied to the correct account. If discrepancies in the sample are identified, staff performs appropriate testing to ascertain the extent of the posting problem and develops an appropriate course of resolution.

- Review previous adjustment requests made to Medicaid. In some cases, adjustment requests may be misrouted and the transactions never completed.

Identification of Overpayments

HMS will accumulate findings by review type and patient type (inpatient and outpatient). All accounts identified as a refund to Medicaid will be entered into our database, along with pertinent information, such as patient name, account number, MID, DOS, TCN, refund amount, and reason for refund. Each account that is reviewed will be logged into our database even if there are no financial ramifications. In cases where no refund is due to Medicaid, an explanation will be recorded.

Once the findings are logged, staff will require signoff on each account that the provider agrees on. Accounts with discrepancies will include findings from both the provider and reviewer.

Exit Conference

During the exit conference, the HMS representative will meet with the provider's staff, review findings, and agree upon a deliverable date for a draft report. The purpose of the exit conference is to discuss findings, make any recommendations, appropriately answer questions about the review/findings, and discuss next steps. Any issues that the provider presents are noted and concerns documented. The provider is permitted to view the summary worksheets and provide explanations for any deviations from policy.

Provider Approval

As part of closing a review, HMS representatives will document all findings and obtain signoff from the authorized provider representative. The provider signoff indicates agreement with the findings. Should the provider disagree with specific findings, their explanations are documented and forwarded to NYS for final decision. The majority of disagreements are resolved during the review process and will require no intervention by NYS.

Report

Following an onsite review, HMS will compile a report that summarizes the credit balance findings and includes a written narrative, including a summary of the review process, findings, and recommendations.

Recovery of Overpayments

At the conclusion of each onsite review, HMS receives a signed attestation from the provider for each identified credit balance. Before these claims are placed into the recovery process, a match against our database of previously-recovered claims, to ensure that claims are not recovered by both the credit balance and third-party review processes. Any claims that match are pulled out for additional review.

HMS also validates the data elements associated with the claims that will be submitted for adjustment. During this process, any claims that cannot be validated against the Medicaid paid claims data are flagged for follow-up by our credit balance team. The follow-up includes QA of all data entry processes, re-review of provider documentation and, if necessary, contacting the provider for further clarification.

The remaining overpaid claims are then placed into the queue for the next submission cycle. Providers are notified that the validated claims will be placed into the upcoming void and adjustment submission.

Provider Education

This process includes a strong provider education component to prevent future overpayments from occurring. Credit balances are caused by a variety of reasons—including claims adjudication issues, patient financial issues, coordination of benefit issues, and the inherent complexity of the healthcare financial environment.

To ensure overpayments are reduced to the greatest extent possible, the contractor will not only work with NYS, but we will also leverage our experience in working with providers and provider associations to educate them on preventing overpayments from occurring.

B.1.b. eReviews – Electronic Auditing

OMIG is working with HMS to develop initiatives that will allow New York State to conduct electronic reviews to determine precise Medicaid overpayments. These initiatives will be driven primarily by cross-matching of paid claims data. By obtaining adjudicated claims information (both payments and denials) from third party payers, Medicaid will now be able to check its payments against third party payments. Below are some examples of payment integrity checks that we will be performing. Taken together, they represent an approach to coordination of benefits analysis that will enable OMIG to institute a universal payment integrity program that can identify and validate overpayments concurrently.

The billing practices described below do not always lead to a Medicaid overpayment; that depends on the actual amounts involved. However, HMS has identified distinct tendencies in how providers interpret billing guidelines and how actual billings appear to change as circumstances change – e.g., Medicaid fee-schedule, third-party fee schedule, Medicaid reimbursement rule when paying secondary to commercial vs. Medicare, etc. Electronic auditing capability will eliminate such biased tendencies.

eReviews will include all provider types for which third-party payer claims detail is obtained.

Examples of Electronic Audits and Reviews

Duplicate Payment Review

Contractor will identify duplicate payments through third-party paid claim matches. When it is identified that a provider failed to report a third-party payment and was subsequently paid by both the third-party payer and Medicaid as primary, the state will recover the Medicaid payment.

Balance Billing

Providers sometimes receive payments equal to the difference between the Medicaid-allowed amount and the primary commercial payment for each claim whose reported commercial

payment is less than the Medicaid-allowed amount for the same service(s). This is inconsistent with Medicaid's billing and reimbursement policies, which allow only for payment equal to the sum of any patient responsibility charges left by the commercial payer.

When HMS identifies through paid claims matches that a provider correctly reported a third-party payment but failed to indicate the patient liability, the state will recover the resulting overpayment.

Charge Review (Bill Audit)
For claims that are dependent on provider charges (high-dollar injection drug charges, pharmacy claims, etc.), HMS will perform targeting and comparative analysis using third-party payer data to identify potential claims for review of itemized bills against submitted charges. When unsubstantiated charges are identified, recovery may occur. The accuracy of the third-party payer data minimizes unnecessary requests for itemized bills and medical records to providers.

B.2. Prompted Provider Self-Disclosures

Section 6402(d) of the Patient Protection and Affordable Care Act of 2010 (ACA) reinforces the obligation for providers to self-disclose identified overpayments. To assist in the recovery and analysis of provider-identified overpayments, HMS is initiating prompted provider self-disclosure mailings. Providers will be required to respond to the requests with identified overpayments, including reasons why the overpayment occurred. Providers will be required to sign an attestation if they report that no overpayments exist.

These efforts will supplement OMIG's existing Self-Disclosure Program by identifying providers based on analyses of billings and Medicaid payments and prompting them to conduct a self review.

B.2.a. Provider Outreach

Initially, HMS will request self-disclosure via mailing notification. After implementation of the provider portal, self-disclosure requests will be performed electronically for providers that choose to use the Web-based platform. The vendor will track recoveries on the claim level, as well as provider responses, which will be available in report format as requested and required by OMIG.

B.2.b. Providing Examples

Wherever possible, the vendor will include examples of potential billing and reimbursement issues that may result in Medicaid overpayments. Providers are required under existing state law to perform a complete review of their patient and financial accounts and report and return identified overpayments. The purpose of supplying "live" examples is to demonstrate to

providers the types of overpayments that may exist and show our commitment to identifying overpayments through data mining should the provider neglect to perform their duties.

C. Complex Reviews

C.1. Long Term Care

C.1.a. NAMI Overpayments

Contractor will perform manual reviews of nursing claims to identify overpayments that resulted from incorrect reporting of net adjustable monthly income (NAMI) amounts. There will be a separate data mining initiative that will look for opportunities to automate the initial identification which will minimize the burden on all stakeholders. This will require additional data feeds from providers and/or the Office of Long Term Care.

D. Additional RAC Provisions

D.1. Provider Portal

OMIG and HMS are developing a payment integrity "provider portal," through which overpayments can be reported and tracked. The primary purpose of the provider portal is to offer both providers and OMIG a Web-based platform which streamlines the communication of overpayment issues. To summarize the main functions, the provider portal will:

1. *Streamline self-disclosure process for all providers.* Facilitating self-reviews and disclosures helps providers better understand billing and reimbursement issues–internal and external–and better position themselves to educate employees and maintain stronger compliance programs.
2. *Automation of refund data aggregation.* HMS will track self-disclosures at the claim level–documenting actual overpayments and reason codes. Doing so enables us to conduct further analyses to identify intra- and inter-provider issues across the program. Through such analyses, HMS "flags" Medicaid-paid claims with potential issues and sends them to providers for an expanded review, while providing OMIG with data to assist in determining future eMedNY edits that will prevent reoccurrences of the identified issue.
3. *Use as a delivery vehicle for desk reviews and eReviews.* Providers will be notified via e-mail when new claims are available for review. HMS will track and analyze responses via the portal in a paperless environment.

Providers who utilize the portal will have the ability to search and locate overpayments (both OMIG-initiated and provider self-disclosed) and use simple data entry functions to report overpayment reasons.

D.2. Underpayments

Separate from communications regarding overpayments, contractor will report underpayments identified through both complex and automated reviews on a quarterly basis. Identified underpayments will only be reported when, through analysis, it is found that a claim was incorrectly billed at a lower level of payment than appropriate. Contractor will not report underpayments in situations where the provider failed to include a provided service on a claim, nor will it process or report underpayments self-disclosed by providers.

D.3. Provider Scoring & Fraud Referrals

HMS will initiate provider scoring based on the results of our integrated reviews. The scoring will utilize tangible data including, but not limited to zero fill behavior, claims adjustments, responsiveness, targeted claims results and self-disclosure analysis. The provider scorecard gives OMIG an additional tool to help recognize specific areas where a provider may be deficient and additional education is necessary while aiding in the identification of potential provider fraud cases.

When HMS Suspects Fraudulent Billing

When, through claims or provider-level scoring analysis, HMS suspects a provider of fraudulent billing activities, that provider, along with back-up documentation pertaining to that facility will immediately be forwarded to OMIG for investigation. HMS will assist OMIG with research and data investigation as is requested, but will not pursue recovery from the suspected provider.

D.4. Provider Appeals

HMS actively mitigates provider disputes and appeals by engaging providers and giving them an opportunity to voice their points-of-view prior to initiating recoveries. When conducting a Payment Integrity Review, staff reviews each potential overpayment at the claim level to precisely identify the overpayment reason and the amount. We also review our overpayment findings with providers prior to initiating recoveries. Such review with providers is conducted during the review and/or at the exit conference. HMS's certified staff provides accurate and

detailed review determinations, including clinical summaries and other documentation to explain why the decision was made. By reviewing specific claims, rather than sampling and/or extrapolation, and obtaining provider attestation prior to initiation recoveries, we are largely able to avoid provider disputes and appeals.

In addition, if a provider disputes our findings during a review, HMS immediately notifies OMIG of the dispute and provides documentation detailing why the claim was determined to be an overpayment. If resolution requires policy clarification, OMIG may consult Department of Health (DOH)'s counsel to obtain a clear ruling on whether the provider is entitled to the payment.

Although HMS makes efforts to address all provider concerns and disputes prior to initiating recoveries, there may be situations where HMS will initiate recoveries without obtaining a provider attestation of their agreement with our findings. This may be true of many complex reviews that require a peer review of medical services.

If a provider disagrees with a recovery initiated by HMS or OMIG, they may request an administrative hearing to contest an adverse determination under the Administrative Procedures Act. During a hearing, the provider will be given an opportunity to present written and/or oral arguments. All records and documents in possession of the agency will be offered and made part of the record in accordance with the law. Once a final determination is made by the administrative law judge (ALJ) overseeing the hearing, each agency involved in the hearing will maintain an index by name and subject of determination. Lastly, providers also have the right to appeal a hearing decision to NY Supreme Court under the Article 78 proceedings.

In the case that an appeal cannot be closed through an informal process and is escalated to a hearing, HMS will continue to assist the state until resolution is obtained. Our staff resources will be available to answer questions, explain the review process and rationale for the determination, and otherwise defend the determination that we made. Staff will comply with all New York State and federal rules, regulations, policies, and procedures and contract requirements regarding provider appeals.

D.5. Coordination with Ongoing Other State Agency Activities

In order to reduce the burden on providers, the vendor will coordinate all provider reviews with OMIG to ensure no overlap occurs. Additionally, previously identified claims that are already included in ongoing New York State or federal payment integrity efforts will be removed from reviews.

D.5.a. Identification of New Findings

When a new data-mining target is identified by the vendor, the claims are presented to OMIG, explaining the methodology used to identify the finding and state and federal regulations to establish good cause for the review of the claim. If it is determined the finding conflicts with ongoing activities being performed by the state or another entity, the claims are removed from the queue of claims for provider review.

D.5.b. Supplement to Ongoing OMIG Activities

At OMIG's request, the vendor will assist in ongoing recovery identification and payment recapture efforts.

D.6. Reporting to OMIG

A minimum of two monthly status meetings will be attended by key HMS project staff, during which HMS will update OMIG on progress, evaluate any problems, and discuss immediate next steps. The vendor will be responsible for scheduling meetings, preparing the agenda and preparing any supporting materials which may be required.

HMS will produce any and all additional reports as required by OMIG.