

Appendices to RFP #20150313

Appendix E – Claim Types

Claim Types By Number and Payment Methodology

Claim Type	Number of Claims FY 2014 (FFS)	Number of Claims FY 2014 (Encounter)	Claim Form	Claim Level	Payment Methodology
Inpatient - Hospital	123,407	0	UB04	Header	APR/DRG
Nursing Facility and Long Term Care	403,995	0	UB04	Header	Per diem
Hospice	16,228	5,805	UB04	Header	Rate
Pharmacy	3,870,322	3,892,651	NCPDP	Header	Point of Sale (POS)
Crossover Part A	65,488	0	UB04	Header	Crossover methodology (deductible, coinsurance)
Crossover Part B	2,495,953	0	CMS1500	Header	Crossover methodology (deductible, coinsurance)
Crossover Part B Outpatient	720,038	0	UB04	Header	Crossover methodology (deductible, coinsurance)
Outpatient – Hospital	690,846	696,265	UB04	Line	OPPS Fee Schedule
Laboratory and Radiology	177,948	208,599	CMS1500	Line	Fee Schedule
Mental Health	1,295,766	506,978	CMS1500	Line	Fee Schedule
Services	609,181	280,071	CMS1500	Line	Fee Schedule
Practitioner/Physician	2,785,152	2,055,877	CMS1500	Line	Fee Schedule
Vision and Hearing	163,476	146,304	CMS1500	Line	Fee Schedule
Medical Supply (DME)	102,119	95,143	CMS1500	Line	Fee Schedule
Transportation (Emergency Ambulance)	32,463	39,062	CMS1500	Line	Fee Schedule
Clinics (RHC/FQHC)	750,315	367,399	CMS1500	Line	Encounter Rate
Dental	518,459	81,170	2012 ADA	Line	Fee Schedule
Home Health	32,694	2,940	UB04	Line	Fee Schedule

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Appendix F – Medicaid Expenditures

Division of Medicaid

Medical Expenditures by Category of Service

Past Three (3) Fiscal Years – FY 2012 to FY 2014

MR-O-01

State Category of Service	Number of Claims Fiscal Year 2014	Fiscal Year End June 2012	Fiscal Year End June 2013	Fiscal Year End June 2014
Inpatient Hospital	119,235	\$617,496,430.27	\$648,722,617.99	\$671,151,312.05
Outpatient Hospital	676,568	\$264,124,132.72	\$192,545,476.80	\$155,511,220.33
Laboratory and Radiology	177,948	\$18,569,325.12	\$12,011,433.81	\$8,692,557.27
Nursing Facility	273,012	\$727,291,593.11	\$719,197,962.57	\$725,763,178.44
Physician	1,964,404	\$290,099,577.52	\$210,710,391.99	\$160,955,661.38
Home & Comm Based Services	648,271	\$191,123,459.10	\$262,637,298.59	\$294,150,031.87
Home Health Services	20,518	\$7,917,757.15	\$2,344,412.17	\$3,515,236.04
Swing Bed Skilled Care	57	\$90,587.66	\$61,658.82	\$189,398.22
Mental Health Clinic Services	1,165,750	\$152,321,293.42	\$114,280,119.53	\$88,172,325.28
EPSDT Screening	349,459	\$23,401,356.95	\$20,863,482.08	\$19,688,022.97
Emerg/Non-Emerg Transportation	32,463	\$14,608,686.50	\$11,605,219.61	\$10,454,270.99
Dental Services	29,320	\$8,825,991.99	\$6,570,122.31	\$4,514,398.65
Eyeglass Services	28,089	\$5,252,004.50	\$3,833,943.54	\$3,018,757.06
Drug Services	3,763,915	\$302,219,440.77	\$273,886,932.45	\$251,848,932.02
Dental Services	488,779	\$76,145,868.76	\$78,251,998.41	\$81,214,428.24
Eyeglass Screening	136,828	\$16,400,115.94	\$17,237,139.52	\$18,524,265.43
Hearing Screening	3,323	\$262,929.64	\$251,509.81	\$396,848.96
Intermediate Care Fac (ICF)	0	\$0.00	\$0.00	\$0.00
ICF – Mental Retardation (MR)	123,070	\$259,889,224.55	\$262,227,363.98	\$268,835,180.67
Swing Bed Inter Care Fac	140	\$212,315.20	\$517,018.34	\$256,752.61
Rural Health Clinic	611,259	\$39,642,870.93	\$37,502,928.38	\$38,558,598.23

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Federally Qualified Health Center	129,759	\$24,131,100.62	\$18,781,631.90	\$14,732,967.87
Medical Supply (DME)	102,119	\$19,136,070.88	\$17,121,770.79	\$17,208,839.28
Therapy Services (Outside HH)	79,705	\$5,728,738.60	\$6,938,804.38	\$8,162,891.81
Inpatient Residential Psych	7,914	\$44,539,051.33	\$45,753,428.13	\$49,652,577.81
Inpatient Free Standing Psych	3,973	\$25,025,378.96	\$26,192,711.30	\$26,883,147.61
Nurse Services	491,259	\$37,872,989.60	\$38,682,534.68	\$35,500,208.95
Ambulatory Surgical Center	9,297	\$5,822,140.34	\$7,070,053.20	\$6,059,123.10
Personal Care Services	6,051	\$8,759,916.00	\$8,932,130.00	\$10,771,547.66
Hospice	16,228	\$31,845,214.68	\$33,483,060.53	\$35,741,763.48
Outpatient Free Standing Psych	0	\$0.00	\$0.00	\$0.00
Mental Health Private	123,097	\$6,945,992.08	\$9,820,468.51	\$9,423,951.02
Family Planning Drug Services	106,407	\$6,478,432.42	\$5,099,040.91	\$4,094,099.36
Free Standing Dialysis	14,185	\$5,389,570.50	\$4,757,800.90	\$2,570,858.23
Managed Care Cap Payments	1,735,364	\$302,681,045.72	\$519,019,361.64	\$732,241,161.61
Dietary and Nutritional Svcs	0	\$0.00	\$0.00	\$0.00
Disease Management Payments	0	\$0.00	\$0.00	\$0.00
Medicare Part A	0	\$0.00	\$0.00	\$0.00
Medicare Part B	0	\$0.00	\$0.00	\$0.00
Crossover Part A Inpatient	42,430	\$44,642,675.81	\$45,549,884.72	\$45,641,017.45
Crossover Part A Swingbed	694	\$34,860.71	\$39,893.20	\$46,631.43
Crossover Part A Hospice	0	\$0.00	\$0.00	\$0.00
Crossover Part A LTC	21,895	\$4,370,734.81	\$2,620,027.02	\$2,809,771.59
Crossover Part A Psych Hosp	468	\$371,345.34	\$383,524.65	\$440,486.92
Crossover Part A HMO/Inst		\$24,131,100.62	\$18,781,631.90	\$14,732,967.87
Crossover Part A Psych Res		\$19,136,070.88	\$17,121,770.79	\$17,208,839.28
Crossover Part B Outpatient	671,597	\$5,728,738.60	\$6,938,804.38	\$8,162,891.81
Crossover Part B DME	322,072	\$44,539,051.33	\$45,753,428.13	\$49,652,577.81
Crossover Part B Transport	82,971	\$25,025,378.96	\$26,192,711.30	\$26,883,147.61
Crossover Part B Psych OP	20	\$37,872,989.60	\$38,682,534.68	\$35,500,208.95

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Crossover Part B Dialysis	48,599	\$16,768,517.09	\$18,817,886.77	\$19,538,994.27
Crossover Part B Physician	2,090,488	\$34,170,792.81	\$35,583,939.81	\$36,712,819.23
Crossover Part B HMO/Profess	0	\$0.00	\$0.00	\$0.00
JO4 NET Accommodation Provider	0	\$0.00	\$0.00	\$0.00
MYPAC Service	7,350	\$19,041,500.00	\$20,847,660.73	\$20,206,949.27
Unknown	10,004	\$870,775.31	(\$25,952.79)	\$6,232.00
Financial Claims		\$661,428,306.75	\$831,547,189.05	\$812,167,032.59
State – TOTAL		\$4,448,186,730.19	\$4,662,105,224.81	\$4,789,977,087.47
State – TOTAL (No Financials)		\$3,786,758,423.44	\$3,830,558,035.76	\$3,977,810,054.88

Appendix G – Existing DOM Recovery Activities

EXISTING DOM RECOVERY ACTIVITIES

DOM Organization and Functions is located on the agency webpage at <http://www.medicaid.ms.gov/>.

OFFICE OF PROGRAM INTEGRITY

The Office of Program Integrity consists of four divisions:

- Investigations
- Medical Review
- Medicaid Eligibility Quality Control (MEQC)
- Data Analysis

INVESTIGATIONS DIVISION

This Division conducts periodic reviews of provider records and interviews with Beneficiaries to verify actual receipt of service for which payments were made. They investigate cases of possible fraud or abuse. This unit is responsible for conducting on-site investigations of providers and for monitoring their utilization in the Medicaid Program.

Cases involving suspected fraud are referred to MFCU. When warranted by the findings of the investigations, referrals are made to the appropriate regulatory agencies such as the Board of Medical Licensure, Dental Board, Board of Pharmacy, or MS Board of Nursing.

Provider investigations could result in monetary recovery, termination as a provider of Medicaid or criminal or civil prosecution through MFCU.

MEDICAL REVIEW DIVISION

This Division is responsible for investigating provider/beneficiary referrals received from outside sources, medical necessity referrals from Medicaid Investigators, and SURS exception data. Registered Nurses analyze data histories and provider files to make qualified medical decisions regarding the appropriateness of services rendered, to ensure quality of care according to standards of practice, to verify services rendered, and to determine medical necessity of procedures performed.

For providers, results can lead to a peer review, possible sanction, corrective action plan, or a referral to MFCU or other appropriate agencies.

MEDICAID ELIGIBILITY QUALITY CONTROL DIVISION

Medicaid Eligibility Quality Control (MEQC) is a federally mandated program whose purpose is to determine the accuracy of Medicaid eligibility decisions made by DOM to allow or deny Medicaid coverage. In the active case review process, eligibility cases are audited for the correct establishment of eligibility for persons actively receiving benefits. From these findings the State Eligibility Error Rate is developed. In a separate audit process, persons or cases whose Medicaid benefits have been terminated or denied are examined to ensure that no one is refused benefits to which they are entitled. This Division assists DOM's eligibility staff in the development of corrective action measures when error patterns or trends are noted in the course of the MEQC review process.

Active Cases

MEQC is responsible for analyzing each factor of Medicaid eligibility as determined by the case eligibility worker and for ruling on the eligibility and/or liability status of the case. The Investigators are currently required to complete ninety percent (90%) of their cases within seventy-five (75) days of assignment and one hundred percent (100%) with ninety (90) days.

Negative Cases

MEQC examines negative case actions (cases in which benefits have been terminated or denied) to ensure that no one is refused Medicaid benefits to which they are entitled. The Investigator is responsible for determining the agency's adherence to (a) timely notice and hearing requirements and (b) eligibility requirements.

Targeted Review

Designed and completed by MEQC to identify the depth of errors in a particular area.

DATA ANALYSIS DIVISION

This Division is responsible for creating algorithms that uncover areas of fraud and abuse in the Medicaid system. The algorithms are created through research using multiple means such as Medicare Fraud Alerts, newspaper articles, websites, and other sources. This Division also develops provider analysis reports for use in Investigative and Medical Review cases, records and collects data for internal and external program integrity analysis reports, and documents the recoupment of funds from Program Integrity cases.

In summary, the Office of Program Integrity serves as an invaluable deterrent to fraud and abuse of benefits in the Medicaid Program.

OFFICE OF PERFORMANCE AND FINANCIAL REVIEW

The Office of Performance and Financial Review monitors contracts and agreements, performs Resident Fund Reviews of participating Long Term Care Provider and audits cost reimbursed providers. Currently this office contracts with an auditing contractor for DSH audits of hospitals receiving DSH payments and other audit functions as needed..

The Office of Performance and Financial Review consists of three divisions:

- Provider Review Unit (PRU)
- Contracts Monitoring Unit (CMU)
- Certified Electronic Health Records Unit (CEHRU)

PROVIDER REVIEW UNIT

This Division is responsible for conducting reviews of cost reports submitted by cost reimbursed providers to verify the accuracy and reasonableness of information contained in the financial and statistical reports. This unit is responsible for monitoring the contractor performing the DSH Audit process mandated by CMS. The unit works closely with the staff of the Office of Reimbursement, which conducts desk review of the cost reports to set reimbursement rates for providers. PRU audits selected cost reimbursed providers to ensure compliance with federal and state laws. This unit provides the Office of Reimbursement field visit reports for reviews performed and/or recoupment information for DSH Audits performed by contractor as a basis for reimbursement modifications when necessary as mandated by the CMS approved Medicaid State Plan.

CONTRACTS MONITORING UNIT

This Division conducts reviews of contractors, including individuals, state agencies, and various organizations which provide assistance to DOM in the administration of the Medicaid program. The unit also conducts annual reviews of

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resident trust funds at all nursing facilities that receive Medicaid funding. These facilities include any nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or psychiatric residential treatment facility (PRTF) funded by the Medicaid program. The CMU is also responsible for receiving and approving payment for services rendered on either a monthly or quarterly basis from certain DOM contractors.

CERTIFIED ELECTRONIC HEALTH RECORDS UNIT (CEHRU)

The CEHR Incentive Payment program provides payments to Medicare and Medicaid eligible providers for the use of CEHR technology in their practice or hospital to improve patient health care. Payments started in 2011 and will continue through 2021. Mississippi Division of Medicaid was an early adopter of the program and started making payments in May of 2011. Prepayment audits are conducted by the CEHR unit using summary information. Post payment audits are conducted by the Bureau of Performance and Financial Review using detail information. Post payment audits are primarily Performance audits verifying:

1. The provider met the program requirement for a specific year. These audits will vary by type of application and the stage of the provider's payment year.
2. Hospital one-time payment calculation is subjected to financial audit to verify the payment amount was calculated within the program guidelines.
3. Quarterly and annual reconciliation of payments made in accordance with the CMS requirements for the payments.

This unit works closely with the program administration group and provides technical support to the administrative group. Prepayment audit steps are reviewed on a periodic basis and recommendations are made to improve the quality of prepayment audits. The prepayment audit group will identify providers that have an unusual entry in their application. The CEHRU will combine this information with their risk assessment of all providers to determine which applications are selected for audit.

OFFICE OF THIRD PARTY RECOVERY

The federally required function of the Third Party Liability (TPL) Division in the Office of Third Party Recovery is to identify possible resources available to pay for medical services for Medicaid beneficiaries, to incorporate this third party data into the MMIS TPL files, and to affect post payment recoveries in order to reduce the expenditure of State and Federal funds. The TPL Office currently augments services with a contractor for various data matching services.

BOOKKEEPING BRANCH

This branch ensures the integrity of third party collections by matching reimbursements with services rendered; processes checks in a timely manner by collecting or refunding payments; compiles financial reports of third party recoveries; and maintains MMIS Financial files as they relate to Third Party Recovery.

BENEFICIARY RECOUPMENT BRANCH

This branch recovers Medicaid payments from beneficiaries who received benefits while ineligible; and receives and processes Improper Payment Reports

BUY-IN BRANCH

This branch monitors the Medicare Part A & Part B program for compliance; reviews Buy-In billing file transactions for corrective action; and resolves Buy-In complaints and related Medicare entitlement.

CASUALTY BRANCH

This branch recovers Medicaid payments for services related to accidents, injuries, malpractice, tort, and paternity. This branch prepares itemizations of payments for court documentation; monitors progress of court action; and educates the legal community of Medicaid's right to recovery. Recoveries are pursued from providers for credit

balances. Additionally, patient liability for long-term care residents is evaluated to determine appropriate payments.

ESTATE RECOVERY BRANCH

This branch recovers Medicaid payments on nursing home and hospital-related services from the estate of deceased beneficiaries age 55 or older when there is no surviving spouse, disabled child in home, and the estate is worth five thousand dollars and zero cents (\$5000.00) or more. This branch prepares itemizations of payments for court documentation; monitors progress of court action; and educates the legal community.

HEALTH BRANCH

This branch investigates the results of third part liability billings sixty (60) days after notice. This branch audits pharmacy edit usage for third party compliance; resolves beneficiary and provider TPL-related problems; and educates beneficiaries, providers, and insurance carriers on TPL policy and procedures to ensure compliance with Federal and state laws.

MMIS FILE MAINTENANCE BRANCH

This branch identifies and verifies the existence should liable third parties for medical coverage of beneficiaries. This branch updates the MMIS RIM (resource information module) files; and guarantees the integrity of TPL files in claims payment subsystem.

OFFICE OF INFORMATION TECHNOLOGY

The Office of Information Technology (iTECH) supports the agency by ensuring the fiscal agent operates MMIS in compliance with key performance indicators and federal, state, and agency guidelines; providing data analysis to support changes in state health policy and health-care reform; and providing state-of-the-art technological support in data processing, communications, and computer training. iTECH, serves as liaison between the fiscal agent and DOM business units to address MMIS system revisions necessary to apply claims edits during claim adjudication; assisting fiscal agent in supporting the business needs of DOM through the utilization of various software and tools, such as Java Surveillance Utilization Review Systems (JSURS), COGNOS reporting, and the Decision Support System/Data Warehouse (DSS).

OFFICE OF COMPLIANCE OVERVIEW

The Office of Compliance is comprised of two areas that together are responsible for the formulation ensuring compliance with State and Federal laws. The Office of Contract Compliance is responsible for ensuring that DOM vendors are in compliance with the terms of their contract and creating procedures for contract monitoring throughout the agency. The Office of Privacy is responsible for ensuring that the Division of Medicaid and its vendors are compliant with all State and Federal privacy laws, including but not limited to HIPAA and the HITECH Act.