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Attachment E - Scope of Work: RAC Program

3.1 RAC Scope of Work and Deliverables

The Vendor’s Proposal shall include a full description of how the Vendor intends to meet the requirements of this RFP. The selected Vendor shall agree to meet all the requirements of the RAC program, which is described in the following sections of this Scope of Work. The Vendor’s Proposal must address all program requirements.

HMS offers DMA a comprehensive suite of analysis, audit, and recovery services to maximize the identification and recovery of improper payments made by DMA to providers. In this section of our response, we present our approach to:

- Identify improper Medicaid payments
- Confirm improper Medicaid payments
- Track and report improper payments to DMA
- Coordinate with DMA to obtain approval for the audit concepts that we develop and support determinations through the appeals process
- Perform recovery of identified improper payments
- Conduct other initiatives relating to fraud investigations and program integrity efforts

Our approach to identifying claims for improper payments is both provider and claims based and spans the full range of Medicaid service types: Inpatient, Outpatient, Durable Medical Equipment (DME), Long Term Care (LTC)/Hospice, Professional Services, Pharmacy, Dental, Behavioral Health, and Waiver programs.

Key HMS capabilities that we describe in this section of our proposal related to recovery audit services include:

- In-depth DMA program and policy expertise
- Documented expertise in developing audit concepts to target improper payments by provider and claim type
- Sophisticated data mining and data analysis capabilities
- Extensive clinical expertise
- Thorough review and audit
- Proven recovery process
- Complete tracking, reporting, and process improvement capabilities

As an integral part of DMA’s Program Integrity Unit, HMS is well aware of the game rules in the spirit of collaboration and transparency between and among DMA vendors. We respect and understand the scopes and efforts of other vendors as DMA continues to build and enhance its robust recovery program by securing an additional recovery contract for RAC and Non RAC reviews. The purpose of this contract is to ensure that all provider types are covered as the existing RAC is limited to certain provider types and other contracts are expiring in the current State Fiscal Year. We are acutely aware of existing scopes and fully understand the need for collaboration to ensure nonduplication of efforts as well as minimizing

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any potential provider abrasions. HMS attends and is in great support of DMA’s approach of inviting all of its vendors to the table, allowing them to be part of the discussion. This is particularly important with multiple vendors and programs.

In-Depth Medicaid Program and Policy Expertise

Improper payment issues across states are often similar; however, policies with regard to coverage, billing, and reimbursement differ substantially from state to state. In addition, state-specific policies and reimbursement guidelines change often, and historical documentation can be difficult to locate and maintain.

The ability to fully research, understand, and apply DMA’s Medicaid program regulations, policies, provider guidance, and reimbursement methodologies governing coverage, coding, and payments for each service type is critical to the success of DMA’s Medicaid Recovery Audit Contractor (RAC) program.

HMS’s Regulatory and Reimbursement Research and Development team includes certified coders, registered nurses, and experienced Medicaid auditors who understand the nuances of program policy and coding issues and are adept at researching the specific regulations and policies related to each audit concept. This team fully researches policies surrounding each audit concept to ensure that our understanding is complete and that our audit approach is consistent with policy.

Accurate and Effective Scenario Development

HMS will work with DMA to identify and develop improper payment scenarios in several ways. We use data mining analytics to independently analyze historical claims data for improper payments and potential improper payment issues. We then research policy and develop proposals for specific audit concepts and populations. HMS embraces a collaborative approach in which DMA and HMS work together to uncover potential program vulnerabilities and implement specific Audit concepts.

Data Analysis and Data Mining Capabilities

HMS’s ability to analyze Medicaid claims, eligibility, and provider data is exceptional. Our data analysis capabilities are anchored by a solid understanding of DMA’s Medicaid Management Information System (MMIS) and program data, built over many years of providing recovery and cost avoidance services on behalf of the North Carolina Medicaid program. Through our contract with the North Carolina Medicaid program, we currently receive claims, eligibility, provider, and other pertinent reference data through File Transfer Protocol Secure (FTPS) on a monthly basis and as requested. This historical and in-depth knowledge of North Carolina data means that we can quickly implement RAC analysis and recovery processes with minimal formatting requirements and demands on DMA, its MMIS vendor, and program resources.

HMS’s data analysis capabilities range from general utilization/cost modeling analytics that can compare DMA claims with national benchmarks for each type of service to identify unexpected areas of cost and growth within the program to highly specific clinical algorithms that target abnormal diagnosis and utilization patterns related to specific procedure codes. Our algorithms apply coding, rules-based, and clinical logic across all claim types. Through these comprehensive analytical processes, HMS can analyze 100% of DMA’s claims in order to identify improper payments and accurately target specific claims for audit and review. Our provider profiling methodologies use the information from the algorithms that we develop and our custom data analysis to calculate provider scorecards. With these scorecards, HMS can identify and prioritize...
providers for audit or review. HMS also deploys advanced data modeling tools to perform statistical data analysis in order to target providers for audit.

**Clinical Expertise**

HMS brings DMA a wealth of clinical expertise and experience in auditing claims and providers across the full scope of Medicaid services. Our staff includes certified coders, registered nurses, physicians, Behavioral Health clinicians, pharmacists, statisticians, pharmacy technicians, data miners, data analysts, and a panel of more than 900 board-certified clinicians and other specialists, representing nearly every AMA specialty. Our Audit teams are structured to align employees with experience, background, and specialty training and/or licensure for each area of audit with specific providers or claims to review. For example, we assign employees with a hospital specialty coding certificate and experience in reviewing hospital claims to our coding reviews and assign registered nurses with medical necessity review training to audit hospital medical necessity claims.

**Audit Capabilities**

HMS uses the same team approach in the development of the audit/review process, guidelines, training, quality assurance (QA), and interrater reliability (IRR). We develop specific audit guidelines for each service type, including inpatient, LTC, physician, pharmacy, DME, End-Stage Renal Dialysis (ESRD), Behavioral Health, and waiver services. Our protocols and processes are supported by extensive proprietary technical process and platforms that enable us to efficiently notify providers; request records (as necessary); and validate, document, and recover improper payments with high defensibility.

HMS auditors are given realistic production goals based on tenure, experience, QA reports, and audit type. Based on our more than 27 years of audit experience, we have developed a balance between quality and quantity. Some audit and recovery companies that set their audit production too high sacrifice quality; when audit goals are too high, auditors tend to skim through records and make rash decisions just to “meet the numbers.” While this type of activity may yield high recoveries during the start-up phase of a project, it will cause complications as the contract progresses. Through our ability to balance quality and quantity, DMA will benefit from sound recoveries; defensible, thorough audits; fewer overturned appeals; less provider abrasion; and, ultimately, less work for its employees.

**Comprehensive Recovery Capabilities**

**Last year, HMS recovered more than $2 billion for our healthcare clients.** These are real recoveries. In addition, HMS interfaces with many MMIS systems and provides electronic recoupment files to the MMIS. We are confident that we can provide any type of electronic (or hard copy) transaction necessary to effect resolution of improper payments or reporting of claim recoveries for DMA. HMS has developed recoupment and recovery experience that will facilitate overpayment recovery efforts as part of this RAC initiative.

On June 28, 2012, the Supreme Court upheld the Affordable Care Act, and most of its provisions, as being constitutional. All of the program integrity requirements and Medicaid RAC provisions were upheld, making this procurement and subsequent contract a necessary component of the State’s compliance with federal law, in addition to being a means to ensure that improper payments in the Medicaid program are identified and recovered.
Tracking, Reporting, and Program Improvement

All claims identified through DMA-approved audit concepts are loaded into HMS’s claim tracking/case management system, Program Integrity Enterprise (PIE). PIE is both a claims tracking system as well as a case management system that supports and documents all aspects of HMS’s audit and recovery process, and tracks activity from the initial notification or records request to complete resolution of the case file. Detailed process flows are automated to support timely medical review monitoring and reporting. Built-in continual time checks ensure that we meet established time requirements. PIE is integrated with letter generation and report generation capabilities, as we describe in our proposal, to ensure the transparency of the entire audit process from initiation through recovery.

A key component of the value that we bring to DMA is our ability to work collaboratively—not only in the identification and recovery of improper payments but also in the identification of program improvement opportunities that can reduce future improper payments. We help clients avoid future improper payments through the identification of potential MMIS system issues, process enhancements, and provider education initiatives. HMS has assisted Medicaid agencies in avoiding millions of dollars in future costs through suggested/assisted process improvements.

HMS’s RAC Solution Meets or Exceeds Provisions of CMS’ Final Rule

HMS’s focus translates into real results that meet both the current and future needs of our clients. For example, the solution that we designed for our first RAC prior to publication of the Centers for Medicare and Medicaid Services’ (CMS) Medicaid RAC Final Rule (see Code of Federal Regulations [CFR] 42 CFR Part 455) has evolved into a robust program that meets or exceeds all of the requirements outlined in the Final Rule. Our experienced team of strategists and product development experts had the expertise and prescience to design a solution with features and functionality that could meet the anticipated requirements. Now that “future” is here, and Exhibit E-1 illustrates how our existing RAC solution meets or exceeds the requirements released as CMS’ Final Rule.

<table>
<thead>
<tr>
<th>Additional Provisions in CMS’ Medicaid RAC Final Rule</th>
<th>HMS Capability</th>
<th>HMS Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number and frequency of medical records to be reviewed by the Medicaid RACs are limited.</td>
<td>✔</td>
<td>HMS’s PIE case management application can limit and track the number and frequency of medical record requests sent to providers and reviewed by HMS in accordance with the limits established by DMA. We work with providers to limit the burden from record requests, including consolidating requests to limit confusion, encouraging the use of electronic medical records, working with providers’ medical record vendors, and granting extensions (if allowed by DMA).</td>
</tr>
<tr>
<td>Medicaid RACs must hire at least one physician Medical Director.</td>
<td>✔</td>
<td>William Mazzella, MD, HMS’s proposed Project Medical Director, is responsible for oversight of all clinical review activities, including physician reviews, assisting certified coders and registered nurses as needed, ensuring the integrity and consistency of audit protocols and the QA program, and participating in appeals/hearings as needed.</td>
</tr>
<tr>
<td>Medicaid RACs must hire certified coders.</td>
<td>✔</td>
<td>HMS employs certified coders trained in national and local coding and coverage policies who follow Internal Review Guidelines (IRGs) to review records from providers for coding and billing errors. Our certified coders have expertise in the full spectrum of service types and issues and follow protocols developed specifically for each approved issue. They have a deep knowledge of state and federal regulations relating to coverage, claiming, reimbursement, and audit of medical records.</td>
</tr>
</tbody>
</table>
### Additional Provisions in CMS’ Medicaid RAC Final Rule

<table>
<thead>
<tr>
<th>Medicaid RACs must work with the State to develop an Education and Outreach program.</th>
<th>HMS Capability</th>
<th>HMS Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>HMS works closely with our clients to ensure that all of the components of our proposed Education and Outreach program accomplish the objectives set forth by CMS and each client. When our Provider Education and Outreach plan is approved by DMA, we will reach out to state provider associations and individual providers to schedule initial meetings and will provide ongoing education and outreach through webinars, newsletters, emails, bulletins, special sessions, and a website with a link to the DMA website.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid RACs must provide minimum customer service measures, including:</th>
<th>✓</th>
<th>HMS maintains a fully staffed Provider Relations function with a toll-free telephone number and trained Provider Relations representatives who are available to respond to providers’ questions and concerns. Our auditors also respond to providers as needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>► Providing and appropriately staffing a toll-free customer service telephone number</td>
<td>✓</td>
<td>HMS proactively validates provider points of contact and addresses and maintains a secure Provider Portal that enables providers to update addresses and contacts at their convenience; they can also update addresses and contacts by contacting our Provider Relations team.</td>
</tr>
<tr>
<td>► Compiling and maintaining provider-approved addresses and points of contact</td>
<td>✓</td>
<td>HMS actively works with providers to encourage the use of electronic medical records and can accept those records on any medium. HMS’s overpayment processes are designed to send determination letters to providers within 60 days.</td>
</tr>
<tr>
<td>► Accepting provider submissions of electronic medical records on CD/DVD or via fax at the provider’s request</td>
<td>✓</td>
<td>HMS actively works with providers to encourage the use of electronic medical records and can accept those records on any medium. HMS’s overpayment processes are designed to send determination letters to providers within 60 days.</td>
</tr>
<tr>
<td>► Notifying providers of overpayment findings within 60 calendar days</td>
<td>✓</td>
<td>HMS actively works with providers to encourage the use of electronic medical records and can accept those records on any medium. HMS’s overpayment processes are designed to send determination letters to providers within 60 days.</td>
</tr>
</tbody>
</table>

| Medicaid RACs must coordinate with audits performed by other entities and should not audit claims that have already been audited or that are currently being audited by another entity. | ✓ | HMS works closely with our clients to ensure that the audits that we undertake are not duplicative of or disruptive to work being conducted by other entities, including state and federal agencies and their contractors. We meet regularly with our clients and other entities to apprise them of our activities and to understand the audits that they are undertaking. PIE, our case management system, is designed to assist HMS in coordinating activities to eliminate duplicate reviews and efforts. PIE enables us to load specific claims from agencies and contractors for match-off, and we can use PIE exclusion tables to exclude specific providers, types of services, and dates. We can also provide extract files to entities for match-off. PIE enables HMS and our clients to ensure coordination of audit activities and avoid duplication. |

| States must incentivize the detection of underpayments and must notify providers of underpayments. | ✓ | Upon implementation of the contract, HMS will work to clearly define the parameters of our underpayment identification, audit, and notification protocols based strictly on the guidance and parameters that we receive from DMA. We will notify the provider and, as requested, assist DMA in adjusting payment to the provider. |

| States must allow appeal rights to providers for RAC audits. | ✓ | HMS understands the appeal process in each state in which we work and provides full support to our clients throughout the appeal and hearing process, including timely development of appeal-related notifications and documentation, preparation of case summaries, and attendance and clinical support during prehearings and hearings. We fully support the providers’ right to appeal our findings if they believe that HMS has made an incorrect determination. We provide clear written notification to providers of their appeal rights and answer any related questions that they have. |

| States may adopt program elements similar to that of Medicare RACs in the | ✓ | During the contract implementation period, HMS will review with DMA the audit processes used in the Medicare RAC and in our... |
HMS brings to DMA to deliver all of the services requested in the Request for Proposal (RFP). Throughout this section, we describe our approach and define the specific capabilities, qualifications, and experience that HMS brings to DMA to deliver all of the services requested in the Request for Proposal (RFP).

<table>
<thead>
<tr>
<th>Additional Provisions in CMS’ Medicaid RAC Final Rule</th>
<th>HMS Capability</th>
<th>HMS Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>following areas:</td>
<td></td>
<td>current Medicaid RAC programs that would be beneficial to the DMA RAC program. HMS has participated in the Medicare RAC as a subcontractor; a number of our staff previously worked for Medicare RAC contractors; and as a leading RAC vendor, we closely monitor the Medicare RAC process.</td>
</tr>
<tr>
<td>► Medical necessity reviews</td>
<td></td>
<td>HMS’s team of registered nurses, certified coders, Medical Directors and physician reviewers, Certified Fraud Examiners (CFEs), and other healthcare professionals have both Medicaid and Medicare RAC experience. We audit all provider and claim types using accepted audit best practices; proven statistical protocols, including various extrapolation methods; and other methodologies required by states. We provide clear detailed rationale and information in all communications; include the Medicaid policies/rules violated; and provide evidence supporting the determination, including a reference to relevant InterQual and/or Milliman criteria if medical necessity is an issue.</td>
</tr>
<tr>
<td>► Extrapolation of audit findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► External validation of accuracy of RAC findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Types of claims audited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RACs must notify providers of overpayment findings within 60 calendar days.</td>
<td>✓</td>
<td>PIE enables provider notification of overpayments almost immediately upon approval by our client. Once approved, our system automatically generates notification letters that are mailed to providers. This dedicated functionality ensures that providers will be accurately notified well within the 60-day limit defined by CMS.</td>
</tr>
<tr>
<td>States should be cognizant of the potential for conflicts of interest and should take steps to identify and prevent conflicts of interest. These conflicts of interest may arise among contractors or their subcontractors that perform audit-related services for providers and then seek to perform audit recovery services on behalf of the State.</td>
<td>✓</td>
<td>HMS is not a claims processor or owned by an insurer or other entity that would cause a conflict of interest. We do not audit a provider on behalf of a state while performing audit services for the same provider to improve reimbursements from state programs. We do not coach providers on coding, documentation, and methods to appeal the very determinations that we make during the RAC review process. HMS is free of conflicts of interest.</td>
</tr>
<tr>
<td>Contingency fees are permissible for the identification and recovery of overpayments from cost-based providers.</td>
<td>✓</td>
<td>HMS has the requisite experience to audit cost-based services to identify and recover potential overpayments and to identify underpayments in states that use cost reports for reimbursement of Medicaid claims.</td>
</tr>
<tr>
<td>States have the flexibility to coordinate the collection of overpayments (direct collection by RAC or recoupment).</td>
<td>✓</td>
<td>In each of our Medicaid engagements, we support the State’s choice of recoupment method; at DMA’s direction, we can recover by using either our established billing and cash management process or a recoupment/offset process.</td>
</tr>
<tr>
<td>States have the responsibility to make referrals of suspected fraud to the State or other law enforcement agency.</td>
<td>✓</td>
<td>HMS has extensive experience in identifying fraud through our Medicaid audit contracts, our CMS Audit Medicaid Integrity Contractor (MIC) contract, and our Medicare Zone Program Integrity Contractor (ZPIC) and Program Safeguard Contractor (PSC) contract work. Our analysts and reviewers are trained to identify potential cases of fraud and to immediately refer those cases with supporting documentation to DMA or to other agencies as directed.</td>
</tr>
</tbody>
</table>

(a) DMA’s Program Integrity (PI) Section investigates Providers when clinically or administratively suspect behaviors or administrative billing patterns indicate potentially abusive, fraudulent or over-utilization activities. The selected Vendor will support Program Integrity’s efforts to ensure that Medicaid dollars are spent appropriately by identifying overpayments and...
underpayments; notifying providers of overpayment findings, and assisting in recoupment of overpayments, as well as identifying avenues for cost avoidance. The RAC post payment reviews conducted by the Vendor shall include the following service types:

(1) Inpatient Hospital NOTE: The Vendor shall not conduct Hospital DRG reviews until after 8/31/12, when the current contract ends

(2) Outpatient Hospital NOTE: The Vendor shall not conduct Outpatient Hospital reviews until after 8/31/12, when the current contract ends

(3) Long Term Care (LTC), including Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for persons with Mental Retardation,(ICF/MRs) and Adult Care Homes

(4) Laboratory and X-Ray Services - Hospital and Free Standing

(5) Specialized Outpatient Therapies, including physical therapy (PT), occupational therapy (OT), respiratory therapy (RT), audiology and speech/language pathology (SLP) services for all ages of recipients. NOTE: The Vendor shall not conduct Specialized Outpatient Therapy reviews until after 10/26/12, when the current contract ends.

HMS will support DMA in its efforts to combat abusive, fraudulent or overutilization activities through the provision of a comprehensive RAC program. We will ensure that Medicaid dollars are spent appropriately by performing identification, validation, recovery, and cost avoidance services as described above in accordance with State restricted reviewed time period limitations. Our activities will include the following service types (following the outlined dates):

- Inpatient hospital
- Outpatient hospital
- Long term care
  - Skilled nursing facilities
  - Intermediate Care Facilities for persons with Mental Retardation (ICF/MRs)
  - Adult Care Homes
- Laboratory and X-Ray
  - Hospital and free standing
- Specialized outpatient therapies
  - Physical therapy
  - Occupational therapy
  - Respiratory therapy
  - Audiology and speech/language pathology services for all ages

(b) The look-back period for reviewing claims shall be three (3) years from the date of the onset of the review. The Vendor shall use generally accepted and valid auditing, accounting, analytical, statistical and peer-review methods.

HMS will review approved claims within a look-back period of three years, using generally accepted and valid auditing, accounting, analytical, statistical, and peer-review methods. In this response, we describe our advanced data mining approach to identifying improper payments and scenario development.

HMS understands the need to be sensitive to providers as stakeholders in the Medicaid payment and integrity process, and we take an integrated approach to identifying providers for audit that includes accurate data analysis, which allows us to develop algorithms and identify improper payments, and the application of DMA rules to select providers for audit.

HMS will support DMA in the identification of improper payments through the development and implementation of data analysis routines, algorithms, and systems that analyze 100% of DMA paid claims to identify claims for audit and recovery/resolution of improper payments.
HMS can work with DMA to identify and develop improper payment scenarios in several ways. We can use our data mining analytics to analyze independently historical claims data for improper payments and potential improper payment issues. We can then research policy and develop proposals for specific scenarios and audit/review populations based on our analysis and research.

### Successful Issue Development

An HMS analyst noted that the MMIS/Point of Sale system has no edits that can prevent simultaneous submission of National Drug Code–coded drug claims and duplicate Healthcare Common Procedure Coding System (HCPCS)–coded drug claims. HMS has identified several hundred thousand dollars in potential improper payments from this data routine in one state alone.

Identification of improper payment issues can arise from a variety of sources, as shown in **Exhibit E-2**.

<table>
<thead>
<tr>
<th>Improper Payment Issues</th>
<th>HMS Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anomalies that can signal improper payment can be identified through comparison of North Carolina utilization benchmarks for specific procedure codes against those of other states.</td>
<td>HMS performed a cross-state analysis of renal dialysis charges for one western state and identified significant vulnerabilities in its payment policies for those services. We recovered more than $1 million in overpayments, and the State saved millions more through making its payment policies more consistent with those of other states.</td>
</tr>
<tr>
<td>Individual provider self-disclosures of overpayments (through claims adjustment, credit balance review, or specific provider self-disclosure process) can be analyzed to determine if the overpayment was a unique occurrence or a potentially systemic issue that should be developed into a statewide audit/review project.</td>
<td>HMS has set up a comprehensive Provider Self-Disclosure program for one large state (including provider outreach and follow-up) and in the first three months returned more than $3 million to the State through that program. These returns were reviewed to identify systemwide issues that should be developed into Audit programs.</td>
</tr>
<tr>
<td>Changes to state policy or Medicare/national coding/clinical guidelines should be routinely reviewed to determine if they lead to a change in system vulnerability.</td>
<td>When Medicare changed the unit billing on one ESRD-related procedure code from 1,000 units dispensed per unit billed to 100 units dispensed per unit billed, states across the country saw massive overbilling for these services. HMS has recovered more than $20 million for states related to this issue.</td>
</tr>
<tr>
<td>HMS auditors are constantly identifying potential new issues as they review claims in the field, and we have developed a monthly process to gather insights and ideas from them.</td>
<td>An auditor recently noticed an unusual credit balance in a provider’s accounts. Research indicated that it was related to a specific billing requirement for “detox” claims and that there was an MMIS system vulnerability that could cause these types of claims to be billed and paid at an erroneous rate. We developed a statewide Review program and recovered more than $17 million for the client.</td>
</tr>
</tbody>
</table>

Our ongoing improper payment recovery projects on behalf of more than 40 state programs and the CMS provide HMS with direct exposure to and experience in new improper payment issues and schemes from across the nation. This will enable DMA to leverage our knowledge, best practices, and experience from Medicaid programs across the country to identify and review improper payments.

In the following section, we discuss in extensive detail our capabilities related to data intake and analysis.
Expertise with Medicaid Data

Accurate improper payment analysis starts with accurate data and a strong understanding of that data. A key component of HMS’s success in Medicaid has been our ability to accurately acquire, process, and understand state MMIS and program data. Every month, HMS receives, copies, reformats, nets, stores, and analyzes more than 150 million new claim records. HMS analysts have extensive experience in working with Medicaid claims, eligibility, and provider data. We currently have more than 10 billion Medicaid claims records in our data warehouse, against which we perform data analysis to identify overpayment recovery opportunities for state clients.

HMS Knows DMA Data

HMS has extensive experience in and understanding of North Carolina Medicaid data. HMS currently receives data files from DMA (through HP Enterprise Services [HP]) on a monthly basis via FTP transmission, including MMIS paid claims, Medicaid eligibility, and provider files. We have worked with these data files for years and have developed a detailed understanding of the data, which we can leverage to quickly implement and maximize recoveries for DMA. HMS team members also have access to QNXT, which allows HMS to even better understand the data and integrate more closely with the MMIS. HMS accurately and securely performs intake of the DMA program’s claims data, program eligibility, provider, reference, and other data as needed. Upon approval, we will use these mechanisms for this engagement.

HMS’s Established Data Protocols

HMS has developed and implemented multilayered systemic and operational protocols and process to efficiently and accurately manage the request, receipt, copying, validation, processing, organization, QA, and control of our client’s data. We have invested tens of millions of dollars in developing and enhancing Health Insurance Portability and Accountability Act (HIPAA)–compliant, Statement on Standards for Attestation Engagements (SSAE) 16 (formerly Statement on Auditing Standards [SAS] 70)–audited technology and infrastructure that enables us as an organization to effectively secure, store, back up, and access that data.

Appropriate Netting of MMIS Voids and Adjustments

HMS recognizes the importance of accurately “netting” claims as adjustments and void transactions made in the MMIS and received by HMS. HMS will process regular claim updates to ensure that our data reflects all adjustments made to date (e.g., provider-initiated adjustments, North Carolina-initiated rate adjustments, and other insurance and improper payment recoveries posted to MMIS). If this process is not accurate, a miscalculation of the actual net amount paid on a given claim could result in false positives and create unnecessary cost; disruption of the process; and, most importantly, provider abrasion.

Our data intake process maintains multiple versions of netting modules that we apply across different claim types/processing dates so we can use the appropriate netting module as the source MMIS data changes. We net all claims as we receive transactions, and we continuously check all claims “in review” against the newly netted claim population to verify active claims. Claims that have been adjusted or voided are flagged and appropriately adjusted in our case management system, PIE, so we cease review activity for those voided claims.
MMIS Data Load

After it has been verified and netted, HMS loads claim, provider, and recipient data into our data warehouse. This claim, provider, and recipient data is mapped into HMS standard data tables defined for DMA. During the load process, we convert data to our standard format; however, we maintain state-specific data elements and values alongside our standard data elements and values. Maintaining both types of data elements and values is an important and intentional element in the design of the consolidated claim database.

HMS has learned that truly standard data elements do not exist in state Medicaid programs; they vary from one program to the next, and each state, even states using the same MMIS vendor, has unique data elements and data values that are critical to understanding why a claim was paid and how reimbursement was calculated. Maintaining state-specific data elements and values in our database enables us to customize each of our scenario edits to each state’s program and guidance. For example, if policy or a state suggests that we exclude Non-Traditional Medicaid program recipients from a scenario, we can use that state’s data elements and values to do so.

Maintaining state-specific data elements and values also enables us to produce electronic deliverables that contain the specific data values necessary for clear understanding and accurate updating of state MMIS systems. HMS produces electronic transactions to update MMIS systems with recovery and recoupment information, and we understand that our systems must conform to DMA’s requirements.

Ensuring Data Integrity

Throughout our data development process, we review and validate the quality of the data received, including the following basic concerns:

► Are all of the expected data elements included?
► Are all data elements populated with values?
► Are the values in each data element valid?

HMS reviews the data transmission process to ensure that it functions appropriately. For this engagement, we will consider the following questions:

► Were our Electronic Data Interchange protocols correctly set up in terms of the State’s requirements?
► Was the data loaded into the appropriate directory?
► Were all components of the transmission complete?

At HMS, the validation and testing of data is an ongoing process since data is so crucial to our business. Accurate intake and understanding of claims data is a central component of our business processes, and we have developed extensive systemic and operational processes that efficiently and accurately control the request, receipt, copying, validation, processing, organization, and QA of client data. We have invested tens of millions of dollars developing and enhancing HIPAA-compliant, SSAE 16 (formerly SAS 70)–audited technology and infrastructure that enables us to effectively secure, store, back up, and access that data. HMS takes great pains to ensure the integrity and validity of the data that we use to identify improper payments because we know how incorrect or incomplete data can lead to inferior results.
Data Mining Analytics and Algorithms

HMS has developed data analysis processes that target improper payment scenarios across the full scope of Medicaid service types, and we can configure them to North Carolina program policies. In addition, HMS is continually researching and developing new algorithms to address each client’s specific program issues. This combination offers DMA the best opportunity to maximize the identification and resolution of improper Medicaid payment issues that exist in North Carolina.

Exhibit E-3 summarizes by service area the types of improper payment scenarios that HMS has developed for other states and can review for DMA, where applicable.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>◆ Appropriate level of care and setting</td>
</tr>
<tr>
<td></td>
<td>◆ Inpatient coding (i.e., Diagnosis-Related Group [DRG])</td>
</tr>
<tr>
<td></td>
<td>◆ Bill audit</td>
</tr>
<tr>
<td></td>
<td>◆ Out-of-state reimbursement error</td>
</tr>
<tr>
<td></td>
<td>◆ Readmissions and transfers</td>
</tr>
<tr>
<td></td>
<td>◆ Never events/Hospital-Acquired Conditions (HACs)</td>
</tr>
<tr>
<td></td>
<td>◆ Duplicate/overlapping payments (multiple types)</td>
</tr>
<tr>
<td></td>
<td>◆ Mother/baby duplicates</td>
</tr>
<tr>
<td></td>
<td>◆ Inpatient/outpatient unbundling</td>
</tr>
<tr>
<td></td>
<td>◆ Balance billing overpayments</td>
</tr>
<tr>
<td></td>
<td>◆ Financial review/credit balance</td>
</tr>
<tr>
<td></td>
<td>◆ Medicare deductible/coinsurance errors</td>
</tr>
<tr>
<td></td>
<td>◆ Medical necessity</td>
</tr>
<tr>
<td></td>
<td>◆ Covered benefit (exclusion)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>◆ Duplicate/overlapping payments</td>
</tr>
<tr>
<td></td>
<td>◆ Unbundling</td>
</tr>
<tr>
<td></td>
<td>◆ Downcoding</td>
</tr>
<tr>
<td></td>
<td>◆ Radiology billing errors</td>
</tr>
<tr>
<td></td>
<td>◆ Anesthesia billing errors</td>
</tr>
<tr>
<td></td>
<td>◆ National Correct Coding Initiative (NCCI) coding errors</td>
</tr>
<tr>
<td></td>
<td>◆ Bill audit</td>
</tr>
<tr>
<td></td>
<td>◆ ESRD issues</td>
</tr>
<tr>
<td></td>
<td>◆ High Cost Drug (HCD) errors</td>
</tr>
<tr>
<td></td>
<td>◆ Financial review/credit balance</td>
</tr>
<tr>
<td></td>
<td>◆ Medicare coinsurance errors</td>
</tr>
<tr>
<td></td>
<td>◆ Infusion therapies</td>
</tr>
<tr>
<td></td>
<td>◆ Specialized therapies (occupational therapy, speech pathology, physical therapy)</td>
</tr>
<tr>
<td>LTC</td>
<td>◆ Excess/duplicate days</td>
</tr>
<tr>
<td></td>
<td>◆ Patient-pay underreporting</td>
</tr>
<tr>
<td></td>
<td>◆ Bed hold days</td>
</tr>
<tr>
<td></td>
<td>◆ Date of death</td>
</tr>
<tr>
<td></td>
<td>◆ Crossover billing errors</td>
</tr>
<tr>
<td></td>
<td>◆ LTC/hospice duplicate days</td>
</tr>
<tr>
<td></td>
<td>◆ Overlapping services included in per diem rate</td>
</tr>
<tr>
<td></td>
<td>◆ Financial review/credit balance</td>
</tr>
<tr>
<td></td>
<td>◆ Cost report auditing</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>◆ Unit billing errors</td>
</tr>
<tr>
<td></td>
<td>◆ Duplicate payment/early refill</td>
</tr>
<tr>
<td></td>
<td>◆ Return to stock overpayments</td>
</tr>
<tr>
<td></td>
<td>◆ Other Third Party (OTB) coordination of benefits (COB) issues</td>
</tr>
<tr>
<td></td>
<td>◆ Duplicate pharmacy/physician therapy</td>
</tr>
<tr>
<td></td>
<td>◆ 340b overpayments</td>
</tr>
<tr>
<td></td>
<td>◆ Fraud patterns</td>
</tr>
<tr>
<td>Home Health</td>
<td>◆ Duplicate/excess billing</td>
</tr>
<tr>
<td></td>
<td>◆ Excess supply utilization</td>
</tr>
<tr>
<td></td>
<td>◆ Medicare-Medicaid (Medi-Medi) duplicate payment and COB</td>
</tr>
<tr>
<td></td>
<td>◆ Medical necessity</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td>► Duplicate procedure billing ◄ Modifier errors resulting in overpayment</td>
</tr>
<tr>
<td></td>
<td>► Medi-Medi duplicate ◄ NCCI</td>
</tr>
<tr>
<td></td>
<td>► Billing for services not delivered ◄ Unit billing errors</td>
</tr>
<tr>
<td></td>
<td>► Upcoding of Evaluation and Management (E&amp;M) services ◄ Multiple/bilateral procedures/co-surgeon cost reduction assistant surgeon</td>
</tr>
<tr>
<td></td>
<td>► Crossover duplicates ◄ Medical necessity</td>
</tr>
<tr>
<td></td>
<td>► Un Bundling ◄ Place-of-service errors</td>
</tr>
<tr>
<td></td>
<td>► Global codes</td>
</tr>
<tr>
<td></td>
<td>► Professional/technical component errors</td>
</tr>
<tr>
<td><strong>Radiology/Laboratory</strong></td>
<td>► Unbundling ◄ Medically unlikely and excess billing</td>
</tr>
<tr>
<td></td>
<td>► Professional/technical component errors ◄ Upcoding</td>
</tr>
<tr>
<td></td>
<td>► NCCI ◄ Medical necessity</td>
</tr>
<tr>
<td></td>
<td>► Upcoding ◄ Orphan lab</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td>► Upcoding ◄ Medi-Medi duplicates</td>
</tr>
<tr>
<td></td>
<td>► Duplicate billing ◄ Drug service ratio</td>
</tr>
<tr>
<td></td>
<td>► NCCI ◄ Age inappropriate</td>
</tr>
<tr>
<td></td>
<td>► Split billing</td>
</tr>
<tr>
<td><strong>DME</strong></td>
<td>► Duplicate billing ◄ Unbundling</td>
</tr>
<tr>
<td></td>
<td>► Medi-Medi duplicate billing ◄ Upcoding</td>
</tr>
<tr>
<td></td>
<td>► Utilization in excess of program limits ◄ Rental cap issues</td>
</tr>
<tr>
<td></td>
<td>► “Miscellaneous code” review ◄ Services billed and not delivered</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>► Duplicate billing ◄ Orphan transportation</td>
</tr>
<tr>
<td></td>
<td>► Medi-Medi duplicates ◄ Unbundling</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>► Excess utilization ◄ Prior authorization discrepancies</td>
</tr>
<tr>
<td></td>
<td>► Unit billing errors ◄ Services do not match treatment plan</td>
</tr>
<tr>
<td></td>
<td>► Nonqualified staff ◄ Documentation issues</td>
</tr>
<tr>
<td></td>
<td>► Billing for services not delivered ◄ Medical necessity issues</td>
</tr>
<tr>
<td><strong>Home and Community-Based Waiver Services</strong></td>
<td>► Excess utilization ◄ Prior authorization discrepancies</td>
</tr>
<tr>
<td></td>
<td>► Unit billing errors ◄ Services do not match treatment plan</td>
</tr>
<tr>
<td></td>
<td>► Nonqualified staff ◄ Documentation issues</td>
</tr>
<tr>
<td></td>
<td>► Billing for services not delivered ◄ Medical necessity issues</td>
</tr>
</tbody>
</table>

HMS will review each issue with DMA prior to any implementation or development by HMS—we will pursue only approved issues. All HMS RAC processes will be completely configured and executed in accordance with DMA’s guidance and instructions. If DMA prefers that HMS not pursue certain types of incorrect payments due to provider sensitivities or for any other reason, HMS can easily remove those targets from our process.

HMS uses a multilayered set of algorithms and analytics customized for each state’s program to identify and target potential improper payments. In the following paragraphs, we provide details on the types of analytics that we will employ for DMA for the RAC project. These include:

- Coding edits and algorithms
- Rules-based billing error algorithms
- Clinical targeting algorithms
Coding-Based Algorithms

HMS’s coding analysis modules use sophisticated database technology, rules-based algorithms, and configurable policy date tables to provide complete, date-sensitive coding review of a state’s claims across a multiple-year period. These algorithms can identify issues related to CMS NCCI rules as well as an expanded set of coding issues developed by HMS’s Clinical and Coding staff. Our coding algorithms are underpinned by sourced, documented, and defensible coverage and coding criteria from the state’s policy and provider manuals, CMS, International Statistical Classifications of Diseases (ICD)-9, ICD-10, Current Procedural Terminology (CPT), AMA, and nationally recognized clinical specialty organizations. We configure our coding rule algorithms for each state to comply with published and nonpublished regulations, and we configure rules to be date sensitive to enable accurate retrospective review. Types of coding issues addressed include the following:

- Duplicate procedures
- Bundling/unbundling errors
- CMS NCCI edits (now required for state Medicaid)
- Global surgical package issues
- Diagnosis/procedure edits
- New patient/existing patient inconsistencies
- Assistant surgeon and multiple procedure coding/payment errors
- Lab panel and fragmentation errors
- Anesthesia billing errors
- Excessive (or impossible) unit errors
- Medically unlikely errors
- Add-on code errors

During project implementation, we configure our coding algorithms to each the State’s policies and will implement each rule only after careful proof-of-concept review and DMA’s approval.

We apply coding rule logic to both individual claims and longitudinal episode-of-care analysis. In episode-of-care analysis, we review all claims from all providers for each recipient to identify improperly billed claims as well as abusive billing patterns. Our sophisticated duplicate detection technology finds adjustment issues, split bills, and line item duplicates across multiple claims for both facility and physician/professional claims.
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HMS Understands the National Correct Coding Initiative

HMS is dedicated to preventing improper payments. As part of our fraud, waste, and abuse services, our Regulatory and Reimbursement Research and Development codes and maintains Medicare, Medicaid, Children’s Health Insurance Program, and NCCI rules in our system. Our focus on researching and coding means that we create edits for most provider types, not just physicians and hospitals. Our program can apply NCCI edits for the following claim types:

- Ambulatory Surgical Centers (ASCs)
- DME
- Hospice
- Outpatient hospital
- Prescriptions
- Ancillary providers
- Dental
- Inpatient hospital
- Outpatient Physical Therapy
- Rural Health Clinics
- Behavioral health providers
- Home Health Agencies
- Laboratory
- Physicians
- Vision

Rules-Based Algorithms

HMS uses a set of rules-based improper payment identification algorithms designed to identify a variety of billing errors based on errors that we have identified through many years of auditing Medicaid claims. We will configure these rules to specific parameters and requirements in DMA’s coding, utilization, and reimbursement policies (e.g., readmissions and transfer policy) and available data elements. HMS uses rules-based billing error algorithms to analyze for improper payment scenarios, such as the following:

- Duplicate claims or charges (HMS has identified more than $10 million to date in duplicate charges/payments for one state)
- Excess unit billing (HMS has identified more than $25 million in excess Epogen® unit billing for three states)
- Billing/payment beyond the date of death (HMS has identified tens of millions of dollars in overpayments for nursing facility days billed beyond a patient’s date of death)
- Hospital/nursing facility/hospice room and board day overlaps (HMS identified more than $6 million in nursing facility/hospice overpayments for one state client)
- Payment in excess of program limits (HMS recently identified more than $3 million in potential overpayments for hours in excess of Personal Care Service daily/weekly limits in one state)

Most of our algorithms incorporate a longitudinal analysis of all claims for a single beneficiary so we can apply the analysis to an entire episode of care or even a multiple-year period. Our process arrays and analyzes claims from all providers for each beneficiary, leveraging claim information to assess overall utilization and billing and allowing us to compare the values and attributes on the claim set to identify inconsistencies between claims that could suggest payment error.

Table-Driven Algorithms Enable Reconfiguration for Policy Changes

HMS’s improper payment targeting algorithms are driven by date and parameter tables so we can apply specific logic to certain dates, provider types, and specific providers as policies and reimbursement rules change. The table-driven architecture also helps us to rapidly implement and test new modules.
Clinical Targeting Algorithms

HMS develops clinically based algorithms to target specific clinical data routines, such as upcoding, inappropriate place-of-service issues, and medical necessity errors. We also target utilization errors, such as excess use of radiology and inconsistent use of DME relative to the patient’s condition.

Our clinical algorithms are based on in-depth knowledge of the clinical and coding issues surrounding specific service types, down to the procedure code level. Our algorithms are developed using a team approach in which registered nurses with many years of experience work closely with data analysts to identify the specific attributes that indicate an illogical situation or likely error.

Our clinical algorithms compare specific attributes of each claim (demographics, diagnosis codes, procedure codes, length of stay [LOS], discharge status, level of care, type of procedures, etc.) to identify discrepancies based on clinical expectations. Inconsistencies are flagged for review.

Exhibit E-4 is an example of a claim that has a combination of attributes that would be identified for review through our clinical algorithms.

Exhibit E-4 ► Example of Record with Potential Coding Compliance Problems

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>5119 Unspecified pleural effusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Diagnosis</td>
<td>4280 Congestive heart failure</td>
</tr>
<tr>
<td>Procedure</td>
<td>9671 Cont mech vent &lt;96hrs</td>
</tr>
<tr>
<td>Discharge Status</td>
<td>01 Home, self care</td>
</tr>
<tr>
<td>DRG</td>
<td>475 Respiratory system diagnosis with ventilator support</td>
</tr>
<tr>
<td>LOS</td>
<td>2 Days</td>
</tr>
<tr>
<td>Payment Weight</td>
<td>3.7291</td>
</tr>
</tbody>
</table>

This record contains the following issues:

► **Coding.** The diagnosis 5119 (unspecified pleural effusion) should not be coded as the principal diagnosis when diagnosis 4280 (congestive heart failure) is present; 4280 should be coded as the principal diagnosis (Coding Clinic, Third Quarter 1991).

► **Clinical.** Procedure 9671 (continuous mechanical ventilation < 96 hours) is not usually performed for either the principal or secondary diagnosis; it needs to be confirmed, or the diagnosis for which it was performed needs to be added.

► **Resource.** The LOS is unusually short for procedure 9671.

On review of this claim and the related medical records, the clinician recommended changing the principal diagnosis to congestive heart failure and the secondary diagnosis to pleural effusion. Respiratory failure was also recommended as a secondary diagnosis. This recoding of the record changes the DRG from 475 (respiratory system diagnosis with ventilator support) to DRG 127 (congestive heart failure), with an associated change in payment weight from 3.7291 to 1.0199, which resulted in a savings to the client of **more than $6,000.**
Provider Profiling

HMS’s Provider Profiling methodologies use the information from our improper payment algorithms and our custom data analysis processes to calculate provider scorecards. Using a provider scorecard approach, HMS can identify and prioritize providers for audit or review.

For example, HMS recently developed a provider profiling analysis to identify providers who may be abusing “zero-fill” claims, claims that occur when a provider has overridden the third party liability (TPL) edits in the system by entering $0 in the TPL payment field. In the profile, HMS developed several attributes in addition to the zero-fill frequency, including the frequency of such often-abused services as diabetic test strips, the frequency that third party payment was reported, the frequency of Medicare-covered services, and the overall claim volume for that provider.

HMS CCAM: Incorporating Clinical Expertise in Analysis of Claims, MDS, RUGs, and ADLs to Target Skilled Nursing Facility Billing Abuse

A challenge in using statistical analysis to find waste and abuse in healthcare data is the fact that individuals do get very sick and require extensive care. Behavioral models such as those used in banking or credit card fraud are not directly applicable; outlier analysis may identify some obvious fraud but will mostly target claims for those who are already very sick, creating a high false-positive rate and a low success rate. However, incorporating clinical understanding into the analysis and adjusting for each patient’s clinical condition will allow for a more accurate analysis of provider data against peers and benchmarks.

For example, HMS analysts recently employed our Comparative Clinical Analysis Methodology (CCAM) to target nursing facilities inappropriately inflating Resource Utilization Group (RUG) scores to maximize reimbursement. CCAM is an analysis method developed by HMS to adjust providers’ billing data for clinical conditions to compare providers with their peers using state and national benchmarks.

HMS’s CCAM process incorporates claims data (both nursing home and other claims) as well as ancillary data (in this case, Minimum Data Set [MDS] and Activities of Daily Living [ADL] data) to build both clinical and billing profiles for each patient. Patient profiles are then compared with state benchmarks to determine if the provider RUG scores are above or below average in relation to similar clinical profiles. Based on the cumulative results of all patient profile comparisons, the provider is assigned a Z-score, which measures cumulative average variance from the norm (a high Z-score indicates greater variance from the norm). Z-scores can be used to compare providers with their peer group across time periods and identify providers with aberrant billing patterns relative to clinical condition (Exhibit E-5).
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Exhibit E-5  
Z-Scores Can Be Used to Compare Providers with Their Peer Groups

When a provider has been selected for audit, the individual clinical/billing profile scores can be used to target specific cases for review. Auditors look for inconsistencies between the clinical profile (e.g., acuity of hospital admission triggering episode of care) and the various RUG utilization categories reported by the nursing facility (e.g., ultrahigh rehab therapy utilization vs. static ADL index) to identify cases and specific claims for review. HMS’s nurses validate the provider’s MDS assessments based on record review.

For one program, this analysis produced more than 44 referrals of nursing facilities for investigation based on extremely high RUG score patterns following low-acuity hospital stays.

Recipient Profiling

A foundation of HMS’s analysis process is our recipient database, and we extend that process in support of our payment integrity efforts through enrollee profiling and longitudinal analysis of recipient claims history. HMS’s Longitudinal Analyzer is a tool that brings together Medicaid eligibility information, TPL and Medicare eligibility information, multiple years of paid claims history, health payor remittance information from HMS’s Accounts Receivable (A/R) system, and such ancillary data as vital statistics and incarceration data. Together, these data sets form a complete picture of each enrollee. We then build analysis modules that can review this holistic picture to identify issues and potential improper payments related to each recipient.

Through this process, HMS can scan claims from multiple providers for the same periods of service, review claim reimbursement and COB across multiple payor eligibility periods, and review medical service utilization to identify areas of potential billing error or overutilization abuse for clinical review.
Predictive Data Modeling

HMS uses advanced data modeling tools to perform statistical data analysis to target claims and providers for audit or new issues for review. Using these tools, we apply analysis techniques, such as cluster analysis, to the review of paid claims against stratified populations as well as against state- and nationwide utilization and billing benchmarks to identify coding and billing patterns outside expected norms. Through this analysis, we can identify new issues to bring to DMA’s attention for potential development into analysis, audit/review, and recovery projects.

A single claim outlier is rarely an error because outlier utilization by definition often occurs based on clinical requirements. However, an ongoing outlier pattern by a provider suggests that billing errors or abuse may be occurring. Simple cluster/outlier analysis alone is rarely sufficient to validate improper payment, but repeated outlier behavior by providers, along with other attributes, suggests that additional detailed (complex) review of that provider’s claims and further investigation may be fruitful.

Predictive Data Modeling Success: Focused Review of ESRD Claims

HMS performed an outlier analysis of provider billing data, including an analysis of provider billings per recipient/per month by outpatient procedure code, for a state client. Several providers’ billing patterns resulted in outlier status, and we reviewed sample claims in detail (in this case, with providers) for related episodes. The sample review identified a common provider billing error pattern that we were able to model in our rules-based improper payment identification algorithms. The rule has since resulted in considerable improper payment recoveries for the state.

The graph in Exhibit E-6 depicts a moving average of Summed Payments per Member per Time period (PMPTP) in a review week. Upper Control limits denote a 95% confidence interval. Episodes above this limit may be a potential credit balance deserving further review. For example, between episodes 15–17, we observe normal PMPTB, spiked PMPTP, and normal PMPTP. Some explanations for this pattern may include:

- Change in membership (to more costly members)
- Change in cost/treatment for members (e.g., Medically Necessary High-Dose Epogen cases)
- Potential billing error
Cross-State Benchmarking

Leveraging the billions of Medicaid claims in our data warehouse, HMS develops cross-state billing, payment, and utilization benchmarks for each type of service and procedure covered by the Medicaid program, which enable us to compare billing/payment and utilization patterns for a state against national or another state’s patterns. This analysis enables HMS to identify anomalies in DMA’s claims data that could represent significant areas of improper payment.

Custom Analytical Processes

A unique capability of HMS is our ability to develop and implement complex, customized data analysis processes to support the identification and recovery of improper payments. These processes go well beyond the boundaries of algorithms or even predictive modeling and can incorporate extensive new types of data.

For instance, on behalf of one client, we are implementing a process to acquire and compare all claims from all payors, including commercial insurance and Medicare, for all Medicaid recipients in the state. We have worked with the state to execute data agreements with carriers/payors, to acquire and analyze data, and to match that data to Medicaid paid claims and encounters to identify overpayments and potential fraud issues.
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The first major audit resulting from this process resulted in more than $3 million in recovery from a pharmacy chain that had systematically overbilled Medicaid.

HMS has developed and implemented a wide variety of customized processes that bring in multiple sources of data to identify improper payments. These systems have supported identification of 340b-related overpayments, Medicaid/Medicare duplicate payments, and date of death–related overpayments and have resulted in tens of millions of dollars in recoveries to clients.

Through the execution of the contract, HMS will review opportunities with DMA for leveraging our capabilities in this area to fully optimize the identification of improper payments for the program.

Reviewing DMA Program and Policies

A critical success factor in implementing data mining for recovery audits is to ensure that algorithms are consistent with the state’s policies. Attempting to apply Medicare or another state’s rules to North Carolina’s Medicaid RAC would result in erroneous findings and significant provider abrasion.

As a recovery and clinical review vendor to DMA for many years, HMS has developed a thorough understanding of DMA’s Medicaid program; its providers; and the program’s policies, procedures, and reimbursement methods.

HMS’s Regulatory and Reimbursement Research and Development team reviews all applicable state, federal, and program policies to ensure the applicability of each issue to the program and to set the appropriate dates and parameters for each algorithm that targets claims for that issue. Our team comprises registered nurses and policy and claims review experts who understand identification and review processes and are experienced in researching the policy, regulatory, and reimbursement issues necessary to support each data routine. This team works closely with the Data Mining team to ensure that the parameters surround each issue can be accommodated by the data.

We understand that our processes must align with both state and federal requirements; therefore, we deem it critical to review all elements that are relevant to the program’s success and compliance with state and federal regulations. Over the years, we have reviewed thousands of Medicaid laws and documents, including the following:

- State Plans
- State Codes
- State Administrative Rules
- State Medicaid Provider Manuals
- State Medicaid Provider Bulletins
- State Medicaid Official Publications
- State Board of Pharmacy Rules and Regulations
- CFR 42
- Medicaid State Operations Manual
- OIG Exclusion Database
- State Exclusion Databases (various)

We will configure our analytical processes to DMA-specific claims data, billing and coding requirements, clinical coverage criteria, and reimbursement policies and practices. HMS will also develop new data analysis routines based on an analysis of specific DMA policies and issues and on our data mining and program analysis activities that review for provider billing outliers and anomalies.
Date-Dependent Criteria

All HMS algorithms and review protocols are date-of-service or date-of-payment dependent. HMS understands that coverage and reimbursement policy changes are generally effective on specific dates, and we have designed our process so we can retroactively review claims and implement the exact policy in place at the time the service was performed or billed (depending on the policy change). In addition, HMS will apply DMA date restrictions outlined in the RFP, such as:

- HMS will not conduct hospital DRG reviews until after August 31, 2012.
- HMS will not conduct outpatient hospital reviews until after August 31, 2012.
- HMS will not conduct specialized outpatient therapy reviews until after November 26, 2012.

Exclusions

As part of our implementation process, HMS will work with DMA to identify all of the services that it wishes to exclude from review, such as:

- Date of service or date of remittance limitations
- Types of service that DMA would like to exclude from review

HMS will implement logic in our identification and QA processes to ensure that we do not select identified exclusions for review or recovery. If desired by DMA and the data exists, we can produce these populations for analysis and exclude them from review/recovery.

A key construct of the HMS’s improper payment recovery process is that unlike many other companies who seek to be RAC vendors, we do not “run” client data through our system. We customize and implement our system and recovery processes specifically for each client. For DMA, we will implement unique modules that fit its data, policy, and regulations as well as DMA’s direction and defined exclusions. “One-size-fits-all” processes that may work across multiple clients in the commercial environment are counter-effective in the state Medicaid environment.

HMS Supports DMA in Ensuring Compliance with CMS RAC Requirements

HMS continues to monitor all correspondence supplied by CMS regarding the implementation of the RAC program. Our Washington, DC–based Government Relations staff routinely corresponds with CMS officials and communicates companywide briefings related to any new federal requirement or directive related to the Patient Protection and Affordable Care Act (ACA) to our Operations teams. They are some of the leading experts in the interpretation of the legislation, as it exists today and will continue to follow all updates as provided by CMS. As such, HMS will remain up to date on all requirements of the ACA.
HMS’s Process for Identifying Over/Underpayment Issues

Extensive data analysis capabilities enable HMS to identify improper payments. Our analysts use advanced tools, such as SAS, Statistics (neural network and predictive modeling), IBM’s Intelligent Miner (cluster analysis, predictive modeling, and neural network), and Data Desk (pattern visualization and identification) to analyze data targets, improve methods of targeting, and identify new improper payment issues. Using our database, we will perform statistical modeling to compare DMA’s claims with nationwide utilization and billing benchmarks to identify coding and billing patterns outside of expected norms.

HMS has quality checks and procedures in place to identify and validate audit concepts. We routinely monitor the effectiveness of each scenario to ensure that it continues to be both effective in identifying improper payments and efficient in that it is not producing false positives that can be burdensome to providers.

We perform trend and pattern analysis using Statistical Process Control techniques to monitor the results of our claim reviews and identify nonproductive targets or growth areas on which to focus. We adjust our data algorithms to improve continually our ability to effectively recover improper payments for our clients. In addition to monitoring target and attribute success, we observe average dollars denied per claim to determine the cost-effectiveness of each target. HMS carefully reviews the results of each data analysis algorithm and carefully validates results to ensure “proof of concept” for each audit concept. We use a multistage approach to ensuring that our data analysis results are targeting improperly paid claims with a high degree of accuracy.

Our work plan for identifying and validating audit issues is described in Exhibit E-6. We describe our testing, verification, and approval processes below.

Issue Review and Development Process

Algorithms Tested through Proof-of-Concept Process

We will thoroughly test all of the algorithms that we develop for DMA prior to proposing them for implementation.

A key issue in data analysis related to the identification of improper payments is “false positives,” data analysis results that look like errors but because of an exception in policy or practice turn out to be correct. HMS understands the negative impact that false positives can have on a recovery project, on providers, and on state stakeholders. We understand the substantial differences between improper payments for a Medicaid program versus Medicare or commercial payors. The CMS rules on which many RAC vendors base their data mining are often not directly applicable to Medicaid programs.
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For example, although many states follow general Medicare principles in their claim reimbursements, specific coding requirements are often quite different.

The application of a Medicare/commercial approach to a Medicaid program such as DMA’s would result in substantial false positives, significant provider abrasion, and likely setbacks to the project.

HMS carefully reviews the results of each data analysis algorithm and carefully validates results to ensure proof of concept for each vulnerability. We use a multistage approach to ensure that our data analysis results are targeting improperly paid claims with a high degree of accuracy, as described below.

The first step in validating the results of each data analysis routine configuration is to review the claims selected by the analysis. In this process, we look at the results on both an individual level and a “macro” level. In doing so, we distribute the selected claims in a number of different ways:

- **Level of error relative to total expenditures.** Does the level of error make sense? If we are finding that 50% of claims are hitting a target, our first thought is that our configuration was wrong. We would go back and verify our research into regulations, our data, and our configuration.

- **Level of error relative to HMS historical data routine experience across Medicaid programs.** HMS has performed improper payment recovery for many states, and we have a good understanding of the level of errors that we expect to see. We find many outlier error rates from program to program, and when we do, we always go back and review our assumptions and our process.

- **Level of error across providers.** Generally, if all providers for that claim type have a high error rate, there is something wrong with our assumptions. Again, we would go back and review the research and configuration of the data routine.

- **Level of error across adjudication dates and dates of service.** This is somewhat dependent on the data routine and state regulations. At times, we look for an even distribution across dates. For example, in the absence of a Provider Education program or major system edit change, we would expect our medical necessity data routine targeting to be relatively consistent across time. For other issues, such as the implementation of new coding policy, we would expect to see a high frequency initially, followed by a quick decline to a baseline error rate.

**Good Cause**

“Good cause” is required for reopening claims that are more than one year old. HMS will present “good cause” language for DMA approval with each new audit issue. HMS’s data mining techniques target potential concepts for improper payments and provide evidence that an improper payment exists. Large volumes of data provided by the State, spanning over multiple provider types, billing codes, and billing formats, are processed by analytical filters that evaluate the data for certain attributes. We conduct regression analysis on the data to narrow further the universe to the potentially erroneous claims. HMS also uses reports from governmental agencies (e.g., the Office of the Inspector General [OIG], Office of the Medicaid Inspector General [OMIG], Program for Evaluating Payment Patterns Electronic Reports [PEPPER], and Payment Error Rate Measurement [PERM]) and aberrancy reports to establish queries for additional potential audits. For each case, we submit documentation, evidence, and our recommendation to audit to DMA’s for approval.
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Good cause exists when there is new and material evidence that was not readily available or known at the time of the initial determination, which may result in a conclusion different from that reached in the initial determination. For example, data analysis that identifies a high error rate or pattern of potential overutilization on the part of a provider or a group of providers is an example of evidence that is not readily available or known to a contractor at the time the initial determination was made. Evidence may include any medical record that documents the medical care provided whether or not the services were “covered, medically necessary, and provided as billed. This includes Medical Records, progress notes, orders, procedure reports, invoices, proofs of delivery receipts or any other documentation.

Good cause may also exist when the evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the initial determination. Such evidence exists if it is clear that the determination or decision was incorrect based on all evidence in the file (e.g., incorrect number of units listed in the claim). Our data mining techniques provide evidence that an obvious error was made at the time of the determination of the decision and therefore allows HMS to review a potential claim to validate the presumption of error.

**Verification Result Documentation and DMA Approval**

When potential audit populations have been tested and verified, HMS will develop a proposal for DMA’s approval of the issue and the audit population. This proposal will contain the following:

- The name of the audit issue, a brief summary, and a summary description of the state policy and/or regulation(s) that apply to the improper payment issue
- Documentation or reference to detailed policy/regulations related to the improper payment issue
- A description of data mining criteria used to target the issue
- Sample claims, with claim-specific rationale describing why each claim in the sample was chosen
- Estimated improper payment amount and impact on providers (number of providers, amount per provider, etc.)
- Type of audit/review (automatic improper payment rule, clinical review, bill audit, etc.)
- Proposed IRGs or audit protocols as appropriate

The Medicaid RAC Statement of Work allows the RAC to look back three years from the initial date of determination with good cause. Pursuant to 42 CFR § 433.312(a), the state must refund the federal reimbursement for unallowable overpayments made to Medicaid providers.
Exhibit E-7 includes documentation that we will submit to DMA regarding each scenario.

### Scenario Development Verification/Approval

<table>
<thead>
<tr>
<th>Mispayment Scenario Development Request</th>
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<tbody>
<tr>
<td><strong>Date:</strong></td>
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<tr>
<td><strong>Opportunity:</strong></td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
</tr>
<tr>
<td><strong>Recovery Type:</strong></td>
</tr>
<tr>
<td>(choose complex record review vs automated review)</td>
</tr>
<tr>
<td><strong>Description:</strong></td>
</tr>
</tbody>
</table>

#### Potential Stakeholders

#### Provider Limitations/Exclusions/Special Requirements

#### Client Approval

- **Decision:** [ ] Approve  [ ] Deny
- **Comments:**

<table>
<thead>
<tr>
<th>Project Parameters</th>
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<tbody>
<tr>
<td>Proposed Dates of Service:</td>
</tr>
<tr>
<td>Estimated Recovery per claim:</td>
</tr>
<tr>
<td>Estimated Recovery per year of service:</td>
</tr>
<tr>
<td>Number of providers:</td>
</tr>
</tbody>
</table>

**Project Support (Federal/State Reg, State Plan, Provider Manuals, etc):**

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HMS will review each proposed audit issue with DMA and obtain formal approval prior to any implementation.
(c) The Vendor shall:

1. Utilize a secure web-based audit management system and provider portal for provider access to Vendor's system;
2. Assist in the development of an education and outreach program;
3. Identify potential fraud, abuse or over-utilization activities that warrant establishing a PI case.
4. Notify the provider of the intended audit; obtain the provider's clinical and administrative records; and conduct the audit;
5. Sample and extrapolate findings when appropriate;
6. Identify overpayments and underpayments;
7. Notify the providers of overpayment findings;
8. Assist in recoupment/recovery of overpayments;
9. Assist in the coordination of reviews with other entities;
10. Through Program Integrity, refer cases of suspected provider fraud to MIU;
11. Participate in the informal and formal appeals processes associated with case reviews;
12. Maintain qualified staff;
13. Perform QA reviews of Vendor staff reviewers; and
14. Provide reports, summaries and updates to DMA Program Integrity as required by DMA.

Our comprehensive RAC solution for DMA will include the following components (Exhibit E-8):

**Exhibit E-8  ► Components of the HMS RAC Solution for DMA**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>Utilize a secure web-based audit management system and provider portal for provider access to Vendor's system</td>
<td>PIE, our audit management system, supports and documents all aspects of our review process and enables monitoring of activity and results by both HMS and our clients. HMS enables providers to directly access information throughout the RAC audit recovery process using our Provider Portal—a proprietary, web-based tool that provides an interface between HMS's Provider Relations staff, our claims database, and providers. We describe these systems in detail in <strong>Response 3.2(a)</strong>.</td>
</tr>
<tr>
<td>Assist in the development of an education and outreach program</td>
<td>Our ability to provide education about the program helps providers gain a better understanding of state rules and regulations, identifies common ground for improvement, strengthens our credibility, and enables us to cultivate an environment of mutual trust and respect. We discuss our approach in <strong>Response 3.2(b)</strong>.</td>
</tr>
<tr>
<td>Identify potential fraud, abuse or over-utilization activities that warrant establishing a PI case</td>
<td>HMS will perform advanced data mining and thorough review of DMA's claims to identify potential fraud, abuse, and overutilization activities that warrant establishing a program integrity case. Please see <strong>Response 3.4</strong>.</td>
</tr>
<tr>
<td>Notify the provider of the intended audit; obtain the provider's clinical and administrative records; and conduct the audit</td>
<td>HMS will send approved Audit Notification letters and medical record requests to providers to obtain information and conduct audits. We describe our approach in <strong>Response 3.5(a)</strong>.</td>
</tr>
<tr>
<td>Sample and extrapolate findings when appropriate</td>
<td>Upon approval from DMA, HMS will conduct sampling and extrapolation activities (discussed in <strong>Response 3.6</strong>).</td>
</tr>
<tr>
<td>Identify overpayments and underpayments</td>
<td>Through our comprehensive identification process, HMS will identify over/underpayments as described in <strong>Response 3.1(b)</strong>.</td>
</tr>
<tr>
<td>Notify the providers of overpayment findings</td>
<td>HMS will notify providers of overpayment findings and send approved Tentative Notice of Overpayment letters, adverse findings charts, refund attachments, appeal attachments, and review tools to providers via certified/tracked mail (Response 3.8).</td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
</tr>
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<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Assist in recoupment/recovery of overpayments</td>
<td>HMS will help DMA to maximize recoveries through our established processes with DMA. Please refer to Response 3.9 for details.</td>
</tr>
<tr>
<td>Assist in the coordination of reviews with other entities</td>
<td>HMS will minimize provider abrasion and ensure that we coordinate reviews with other entities. We discuss our approach in Response 3.10.</td>
</tr>
<tr>
<td>Through Program Integrity, refer cases of suspected provider fraud to MIU</td>
<td>HMS will immediately refer suspected fraud through DMA to the Medicaid Investigations Unit. We will submit a case summary report within two State business days of the suspected fraud. Please see Response 3.11 for details.</td>
</tr>
<tr>
<td>Participate in the informal and formal appeals processes associated with case reviews</td>
<td>As described in Response 3.12, HMS will participate in the informal and formal appeals processes associated with case reviews.</td>
</tr>
<tr>
<td>Maintain qualified staff</td>
<td>HMS will maintain sufficient, qualified staff for this engagement. Our staffing plan is described in Attachment F.</td>
</tr>
<tr>
<td>Perform QA reviews of Vendor staff reviewers</td>
<td>In Attachment G, Response 3.14, HMS describes the QA activities that will ensure that our deliverables are accurate for this engagement.</td>
</tr>
<tr>
<td>Provide reports, summaries and updates to DMA Program Integrity as required by DMA</td>
<td>HMS will provide reports to DMA that comply with its format, frequency, and media requirements. Please see Attachment G, Response 3.15 for details.</td>
</tr>
</tbody>
</table>

(d) The Vendor shall be allowed up to three (3) calendar months from date of contract award for the Contract Implementation Period. By the end of this period, DMA requires that the Vendor shall have completed deliverables due during this 3-month period, as referenced in this RFP including, but not limited to documenting and establishing procedures, hiring staff, managing the development of the technical components of the contract, and preparing for the start of Provider review activities. If required tasks have not been completed during the 3-month implementation period, once the Vendor begins conducting Provider reviews, a one-time reduction in compensation will be imposed. DMA will reduce the Vendor’s contingency fee rate by 1% for each month beyond the 3-month implementation period that it took to complete the required tasks.

HMS’s proposed start-up approach to our recovery audit projects on behalf of DMA is the result of our experience in implementing recovery projects for more than 40 state Medicaid agencies across the country. Although each state agency and each implementation are different, our experience has enabled us to develop and continually enhance our project implementation capabilities. We are experienced in working with Medicaid Program staff, Fiscal Agents (FAs), and MMIS data and in implementing large-scale review and recovery processes. We have developed project management and technical capabilities that enable us to implement projects efficiently, effectively, and with the least impact on DMA staff and operations. During the 3-month implementation period, HMS will complete the following deliverables: documenting and establishing procedures, hiring staff, managing the development of the technical components of the contract, and preparing for the start of provider review activities. We understand that DMA will reduce our contingency fee rate by 1% for each month beyond the 3-month implementation period that it takes to complete the required tasks.

HMS is a national organization, with the management, staff, technical, and operational resources necessary to support multiple projects simultaneously. Project implementation challenges sometimes do arise—but as a large organization familiar with contingency fee recovery contracting for Medicaid, we have the resources and long-term outlook required to invest appropriately in any necessary development to ensure that contracts are successful for DMA and are implemented according to State priorities and expectations.
Beginning a recovery audit project requires attention across multiple functional areas, including:

- **Project management process.** Our management process handles the protocols and procedures necessary for working and communicating effectively with state agencies in the implementation and execution of each project.

- **Data acquisition.** Acquiring and understanding the claim, provider, recipient, and support data that enables accurate targeting of improper payments is key to a successful project.

- **Recovery audit support systems and infrastructure.** Our PIE claims tracking database supports all aspects of our review, recovery, and reporting process, and our Provider Portal facilitates communication with providers. Our extensive data transfer and MMIS interface capabilities enable the recovery process.

- **Improper payment identification, approval, review, and recovery process.** HMS seeks to implement a collaborative process that leverages our experience and capabilities with agency/stakeholder knowledge and understanding to achieve a comprehensive, effective, and appropriate improper payment identification and recovery process consistent with DMA’s priorities and expectations.

- **Provider and stakeholder outreach.** HMS understands the importance of providers and stakeholders to DMA. A core element of our approach is to work with DMA to implement outreach and communication processes that assist providers in understanding the RAC process and reducing their concerns about the program.

In this section, we discuss our proposed start-up activities related to each of these functional areas, recognizing that the most critical element in our approach is to configure each project to the requirements and expectations of the DMA program.

**Start-up Planning**

HMS’s project start-up and implementation planning process begins immediately on contract award. After we are notified of an award, we begin the process of arraying Project staff, re-reviewing RFP requirements, finalizing a proposed work plan, and allocating technical resources. Our National Regulatory and Reimbursement Research and Development team review Medicaid provider manuals and policy bulletins in preparation for an official project Kickoff meeting and the project’s implementation phase.

On contract signing, our contract manager will immediately reach out to appropriate DMA staff to schedule the Kickoff meeting and subsequent requirements gathering. We will offer DMA immediate access to HMS management as needed, providing staff with email/office addresses and telephone numbers for all key staff as well as the home telephone number of the contract manager.
Leveraging Current Projects

HMS currently has contracts in North Carolina, which give us a significant advantage in the start-up and implementation process for this engagement. Although this is a separate contract with different management, processes, and operational protocols, our experience provides a head start in understanding DMA's program, MMIS (and upcoming changes), policies, data, and providers. Because we already have an understanding of the data and data transfer process, our existing contracts provide opportunities to streamline the current data process, which will minimize effort and costs for DMA and MMIS staff. Reducing data intake time will enable HMS to begin the improper payment identification, proposal, and review process on an accelerated basis.

Project Start-up

Project Management

A critical component of any recovery audit project is establishing an effective process for working with the client to ensure that 1) the State has full insight, input, and control over HMS activities and 2) HMS benefits from our client’s knowledge and insight about its program, claims, and providers.

Kickoff Meeting

After a contract is signed, the formal project start-up process begins with a Kickoff meeting that HMS will seek to schedule as soon as possible. By the Kickoff meeting, our start-up activities will be well under way. We will have abstracted requirements from the RFP; outlined data/technical requirements based on existing data (as applicable); reviewed State coverage, coding, and reimbursement policies; and developed an understanding of State audit parameters.

At the Kickoff meeting, we will be prepared to introduce HMS and our team and have a substantive discussion with State staff about the requirements, configuration, and implementation of the project. Agenda items that HMS will be prepared to discuss at the Kickoff meeting include the following:

- Introduction of HMS and Project staff
- State contacts and roles/responsibilities
- Meeting and communication protocols
- Reporting process
- Contract requirements and parameters
- Project implementation plan

- Data acquisition process
- Proposed areas and opportunities for improper payment review
- Provider and stakeholder outreach
- Recovery process and protocols

An important goal of the Kickoff meeting is to begin the requirements-gathering process necessary to enable configuration, testing, approval, and implementation of the project according to DMA’s requirements. Based on the meeting, we will assign responsibilities and expected time frames for next steps in the implementation process.

HMS will maintain and publish minutes of all meetings, and we will track next steps and obtain approval at the completion of each step in the process. At each meeting during the implementation phase, HMS will present a schedule of outstanding items to DMA, and we will track the status of each item and, as approved, will document approval by date and name of approver. We will use that list during the project start-up and implementation phases until DMA approves all plans and documents, and the complete list will become a part of the documentation and working papers kept by HMS.
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Project Protocol Development

A critical piece of the start-up and implementation processes is to identify DMA directives, preferences, and governing principles related to each aspect of the project scope, including:

- Meeting/contact protocols
- Information request protocols
- Provider/stakeholder communication protocols
- Improper payment scenario proposal/approval protocols
- Audit plan proposal/approval protocols
- Record request protocols
- Review process protocols
- Improper payment notification processes
- Appeals protocols
- Recovery protocols
- Reporting protocols

As part of the start-up process, HMS reviews any available State policy/regulation related to these areas (e.g., provider audit limitations, appeal time frames), and we discuss the project management process with State staff. We incorporate the results of this review into proposed operational protocols that we share with the State for approval. When the protocols are approved, we incorporate them into our operational manuals for each contract and into training programs for Project staff. We recognize that such protocols are subject to change, and during the start-up and implementation phases, we will define with DMA the change management process for proposed updates to operational protocols.

Project Management and Implementation Plan

A major deliverable during the start-up process is an approved implementation plan that is developed under the leadership of our Recovery Audit department to ensure that organizational resources are aligned and available to fulfill the start-up and execution requirements of each project.

HMS has developed the management experience, methodology, tools, technology, and operational infrastructure necessary to ensure the effective and timely execution of the contract tasks, activities, and functions required by this scope of work. We bring experience in managing small, medium, and large engagements, including recovery audit and other cost management projects. Our success in designing and consistently implementing engagements on time—then managing them to ensure that our clients achieve optimal results—is based on the project management approach that we deploy to ensure that all tasks, activities, and functions are completed effectively and in a timely manner. Key components include the following:

- A Project Management Institute (PMI)–based project management approach supported by effective project management tools that incorporate the planning, accountability, and transparency necessary to plan and coordinate resources across a complex engagement and ensure that all activities and tasks are completed according to the approved work plan
- A Project team with in-depth knowledge of Medicaid programs, specifically DMA programs, and experience in managing the start-up and implementation of Medicaid contracts, including recovery audit services.
- Proprietary systems and case management tools that deliver the monitoring, measurement, and reporting capabilities required to support recovery audit activities in multiple states, leveraging HMS’s in-place technology and organizational structure to support services provided to more than 40 state Medicaid agencies.

As a current partner to DMA and many other Medicaid agencies, HMS anticipates minimal impact on State staff and resources in implementing our RAC program.
HMS’s Proven Project Management Approach and Tools

Project Management Approach

In the implementation and management of complex engagements, HMS adheres to the PMI’s project management methodology. Our approach combines planning and performance, communication, quality, risk, and time management practices with comprehensive reporting capabilities, and we deliver a full suite of management tools to anticipate, monitor, and verify our operations.

Exhibit E-9 illustrates our project management approach.

Exhibit E-9  ► HMS’s Project Management Methodology Ensures Project Success

HMS’s approach to project management involves several major components that when fully integrated support the efficient operations of each project. HMS is committed to continually and consistently setting new goals, creating and implementing action plans that are appropriate for the services requested in the DMA RFP, measuring results, evaluating employee performance, and refining tasks where needed.

Our ability to successfully deploy and deliver large projects similar to that proposed for DMA is driven by the following elements:

► Deployment of the optimal organizational structure and refining it as needed to meet DMA’s unique requirements
► Adherence to DMA-tailored best practices and protocols
► Use of state-of-the-art systems and tools with a focus on constant innovation, including our proprietary claims tracking/case management system, PIE
► Provision of information via both formal and informal meetings, reports, and other vehicles to ensure clear, concise communications
► Assignment of key personnel who have deep experience in all facets of the services to be performed for DMA
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Structured supervision and management in accordance with HMS’s project management methodology

The combination of each of these factors creates a strong foundation for consistently achieving results. HMS’s overall project planning incorporates:

- The use of a detailed project work plan that specifies timelines, resources, and task assignments
- Project activity and task scheduling employing project timetables that outline steps for accomplishing goals
- Resource assignment by hour and advance reassignments based on changes to the project
- QA reviews of project progress and results by expert technical advisors
- Ongoing daily monitoring of task performance using status reports and automated tracking
- Planning and processes that ensure the highest levels of adherence to security currently required by law and contemplated for next-generation technologies

HMS is committed to maintaining a sound project control structure and a compliant operation for every project, and our engagement with DMA will be no exception. Our team is dedicated to establishing and maintaining that structure throughout the course of the engagement. Our Project team stands ready to serve DMA with a proven approach and a commitment to the highest standards of performance and conduct.

**Project Management Methodology**

In the planning and implementation of the scope of work for DMA and the development of key deliverables on an ongoing basis, HMS will leverage the resources and expertise of our central Project Management Office (PMO). Using the PMI-based approach discussed above as well as the tools discussed below, the project management implementation manager will develop our work plan and, after it has been approved, execute the plan and ensure timely implementation of all components of the scope of work.

Additionally, we will conduct high-level quality monitoring throughout the contract to ensure the highest level of service and continuous improvement, using the Define/Measure/Analyze/Improve/Control (DMAIC) methodology. DMAIC is a component of Six Sigma, a business management strategy based upon years of proven management techniques to ensure that projects are run accurately, the customer is satisfied, and business processes continue to achieve successful results.

**HMS Gives Ongoing Support to DMA**

Our staff and resources not only support our implementation process but also give ongoing support to ensure operational success. When the implementation phase of the project is complete and the contract enters the operations phase, the PMO serves as an ad hoc resource available to project management to ensure the project’s success. For example, as we develop new concepts, we may require analysis that involves new types of data files. The Project Management team may determine that in order to achieve agreed-upon time frames, additional technical resources are required to acquire and integrate the new data sources into our analysis process. In this situation, HMS will identify and allocate the necessary corporate resources; plan the project; assign tasks, priorities, and timelines; and monitor activity against the plan to ensure that the new data analysis is delivered within the established time frame.
Spotlight on HMS Project Management Resources

► **Project Management Office methodology.** The PMO methodology enhances HMS’s service delivery excellence by coordinating the planning, prioritization, and execution of projects that are tied to the client’s overall business objective.

► **Project Management Institute.** The PMI is the world’s leading not-for-profit membership association for the project management profession, with more than half a million members and credential holders in 185 countries. The mission of the PMI Global Standards Program is to improve the understanding and practice of project management by identifying, defining, documenting, and championing generally accepted project management practices and a common project management lexicon (www.pmi.org).

► **A PMI-certified project management implementation manager.** HMS employs certified project managers.

► **DMAIC.** DMAIC includes steps from the Six Sigma quality improvement methodology that HMS employs:
  - **Define.** Define the goals/scope of the project.
  - **Measure.** Measure the performance of processes/procedures.
  - **Analyze.** Analyze performance in terms of future requirements.
  - **Improve.** Ensure all that expectations/requirements are met.
  - **Control.** Initiate project improvement processes.

Our Quality staff includes experts trained in HIPAA compliance, many of whom hold Six Sigma certification.

DMA will experience the following benefits from our PMO methodology:

► Demonstrated ability to rapidly implement data and deliverable contracts. Project management best practices have resulted in a 67% reduction in time to market.

► Expert staff in direction, management, and analysis of data- and deliverable-driven projects.

► Ongoing assistance throughout the life of the contract to ensure timeliness for data analysis and deliverables to the client.

HMS's project management approach supports our ability to help DMA identify improper payments and recover overpayments due to waste or abuse. We have the people, tools, processes, and structure in place to manage, control, and evaluate the projects that we propose to deliver to DMA.

**DMA will receive exponential benefits from our integrated processes.** For ease of review, HMS provides an **Implementation plan**, detailing the comprehensive tasks associated with initiating the project.

**Project Implementation**

HMS will work closely with DMA to review, discuss, and finalize the project plan for each phase of the project that identifies the scope of work, detailed steps, time frames, and resources for all work to be performed; State involvement; and all other facets of the project. We have organized the plan for the implementation phase into two core areas:

1. Task/subtask items related to the creation of the required primary database structures
2. Task/subtask items per deliverable

HMS will meet with DMA for a Kickoff meeting after contract award. During this meeting, the initial project plan will be discussed in detail, outlining mutual agreement on contract scope and deliverables. HMS will revise the project plan as required with the results from this initial meeting and will ensure a timely, accurate project plan throughout the
engagement. HMS will submit the final project plan to DMA for review and approval of all activities relating to the implementation phase prior to execution.

Exhibit E-10 contains a draft implementation plan for this engagement. Many tasks run concurrently.

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeline</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Kickoff Meeting</td>
<td>2 Days</td>
<td>Contract Manager</td>
</tr>
<tr>
<td>2 Weekly Status Meetings</td>
<td>8 Weeks</td>
<td>Contract Manager</td>
</tr>
<tr>
<td>3 Data Requirements and Intake</td>
<td>5 Weeks</td>
<td>Implementation Manager</td>
</tr>
<tr>
<td>4 Contract Deliverables</td>
<td>4 Weeks</td>
<td>Contract Manager</td>
</tr>
<tr>
<td>5 Letters Approved</td>
<td>2 weeks</td>
<td>Implementation Manager</td>
</tr>
<tr>
<td>6 Audit Protocol Established</td>
<td>3 Weeks</td>
<td>Implementation Manager</td>
</tr>
<tr>
<td>7 Recovery Approach Determined</td>
<td>3 Weeks</td>
<td>Implementation Manager</td>
</tr>
<tr>
<td>8 Appeals Process Determined</td>
<td>2 Weeks</td>
<td>Implementation Manager</td>
</tr>
<tr>
<td>9 Reporting Requirements</td>
<td>4 Weeks</td>
<td>Implementation Manager</td>
</tr>
</tbody>
</table>

**Scenario Development**

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeline</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Policy and Regulation Research</td>
<td>30 days</td>
<td>Regulatory and Reimbursement Research and Development Manager</td>
</tr>
<tr>
<td>11 Research and analysis</td>
<td>30 days</td>
<td>Regulatory and Reimbursement Research and Development Manager</td>
</tr>
<tr>
<td>12 Data Mining Development and Testing</td>
<td>15 days</td>
<td>Data Analytics Director</td>
</tr>
</tbody>
</table>

**Automated Review**

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeline</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Data Mining and Research</td>
<td>15 days</td>
<td>Regulatory and Reimbursement Research and Development Manager</td>
</tr>
<tr>
<td>14 Exclusions</td>
<td>10 days</td>
<td>Data Analytics Director</td>
</tr>
<tr>
<td>15 Notification</td>
<td>10 days</td>
<td>Automated Review Director</td>
</tr>
<tr>
<td>16 Provider Services Training</td>
<td>3 Days</td>
<td>Automated Review Director</td>
</tr>
</tbody>
</table>

**Complex Review**

*Note: Reviews are ongoing; we depict here the steps for one cycle.*

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeline</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Data Mining and Research (or Referral)</td>
<td>15 days</td>
<td>Regulatory and Reimbursement Research and Development Manager</td>
</tr>
<tr>
<td>18 Exclusions</td>
<td>10 days</td>
<td>Contract Manager</td>
</tr>
<tr>
<td>19 IRGs</td>
<td>14 Days</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>20 Notification and Record Request</td>
<td>10 days</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>21 Record Receipt</td>
<td>30 days</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>22 Review and Determinations</td>
<td>60 days</td>
<td>Clinical Supervisor</td>
</tr>
</tbody>
</table>
| 23 Quality Review Performed             | 60 Days   | Quality Assurance Director                                        | (performed concurrently with)
Another critical component of the start-up process is initiation of the data acquisition process. Accurate improper payment identification and recovery starts with accurate data and a thorough understanding of that data. A major component of HMS’s success on behalf of Medicaid programs has been our ability to efficiently and accurately acquire, process, and understand our client states’ MMIS and program data. We currently have more than 10 billion Medicaid claims records in our data warehouse, against which we perform data analysis to identify improper payment recovery opportunities. Every month, HMS receives, copies, reformats, nets, stores, and analyzes millions of new Medicaid claim records.

To accomplish these tasks, we have developed effective data intake technology and processes that we will leverage for DMA. Our scalable technology enables us to add intake, storage, and processing capacity quickly and easily. Because of this functionality, we can easily configure, process, and analyze data for DMA while maintaining appropriate security and HIPAA compliance. The following components are included in our start-up activities:

- MMIS system analysis and data request
- Leveraging of existing data transfer processes
- Data extraction and validation
- Data validity testing
- Netting of MMIS voids and adjustments
- MMIS data load

Recovery Audit Support Systems

HMS will also use the project start-up phase to begin implementation of our recovery audit support applications (PIE and Provider Portal) and infrastructure. We have developed this infrastructure specifically to support review of claims and recovery/resolution of improper payments. During the start-up process, HMS will provide DMA with an overview of key applications and discuss with DMA how each application is applied in the review/recovery process. The full implementation of these platforms will continue through the requirements-gathering, configuration, testing, and user acceptance phases.

Improper Payment Identification, Approval, Review, and Recovery

The most important component of the project start-up phase is to begin discussing DMA’s preferred approach to the identification and recovery of improper payments.

HMS has considerable experience and expertise in identifying, reviewing, and recovering improper payments, but we recognize that DMA has its own priorities and vision of how the process should be structured. Our goal during the project start-up phase is to meet with appropriate stakeholders to share our experiences and observed best practices related to identification and recovery and, more important, to understand and plan the configuration of our processes to match the approaches preferred by DMA. In addition, start-up discussions provide an opportunity to learn from stakeholders who have the best understanding of where potential vulnerabilities exist as well as the issues and challenges that we will encounter. These discussions will consider the topics described below:
Provider and Stakeholder Outreach

During the project start-up phase, HMS will also address our approach to provider and stakeholder outreach for DMA. HMS understands that a RAC program can concern providers, who are worried about potential recoveries as well as the cost associated with responding to record requests and findings. HMS’s approach to recovery audits attempts to reduce provider concerns and make the recovery audit process as painless as possible.

During the start-up phase, HMS will work with DMA to develop a plan to configure our approach to providers and a provider communication and outreach plan that includes the following elements:

- RAC website
- Webinars and provider association meetings
- Provider bulletins

Approved Work Plan

The outcome of discussion and planning related to each project component during the start-up phase will be reflected in our project work plan, which will be presented to DMA for approval and regularly reviewed with DMA. The work plan will reflect detailed implementation steps for each of the project components initiated during the start-up phase, including requirements gathering, configuration, testing, user acceptance, implementation, ongoing operations, and project closure.

(e) It is reasonable to expect that the Vendor will review approximately 100 RAC cases per month. However, DMA does not guarantee that the Vendor will achieve projected workloads at any time during the term of the contract. At the same time, DMA is not setting a cap on the volume of reviews to be conducted. The projected value of identified Medicaid underpayments is unknown; however, according to CMS, during FY 2010, 82% of Medicare RAC corrections were collected overpayments and 18% were identified underpayments.

HMS understands that we may or may not review 100 cases per month and that DMA is not setting a cap on the volume of reviews to be conducted.

3.2 Audit Management and Tracking

The Vendor shall manage cases and track audit and review findings. Providers must be given access to Vendor’s audit management and tracking data to determine the status of their case. The Vendor must also provide Program Integrity staff with all audit management and tracking data for QA reviews, reporting and other internal functions. The Vendor shall support an Education and Outreach Program, as outline in RFP Section 3.3 and as per CMS requirements.

(a) The Vendor shall manage all aspects of the case review and assist in coordinating reviews and audits for North Carolina to help prevent the audit of claims that have already been audited or that are currently being audited. Access to information must be secure and in compliance with 45 CFR 164.502(b). The Vendor’s Proposal shall include detailed descriptions of how the Vendor will perform necessary functions, including, but not limited to:

(1) Tracking all case activity;
HMS will manage cases and track audit and review findings through PIE, to which DMA staff will have access. Providers will have access to our Provider Portal, which will include case status information. We will provide Program Integrity staff with audit management and tracking data for QA reviews, reporting, and other internal functions. In addition, we will support a Provider Education and Outreach program as described in Response 3.3.

In the following paragraphs, we describe the components of our PIE and Provider Portal systems, which allow us to:

- Track all case activity
- Track anticipated recoveries, overpayments adjusted, and final recoveries in an A/R application
- Make entries associated with each case
- Track over/underpayments identified and communicated to Program Integrity
- Document case-related communications
- Generate case-related review tools, letters, and attachments
- Provide standard and ad hoc reports
- Obtain electronic records from providers

The Provider Portal is also capable of serving as a means for “Self Disclosure,” providing one point of reference for providers to self-disclose overpayments. Providers often do not have an effective means for coming into compliance without a robust program to self-disclose. This process brings DMA the ability to analyze and reverse engineer every disclosure, finding the root cause of the overpayment. A more efficient and effective solution for self-disclosures increases the refund activity significantly.

**PIE Is HMS’s Comprehensive Case Management/Tracking Tool**

All claims identified through DMA-approved data routines designed to target improper payments are loaded into HMS’s claim tracking/case management system, PIE. PIE can also accept manual or electronic referrals of cases and claims from DMA or other stakeholders, if directed.

**PIE Facilitates Transparent Review**

PIE is both a claims (data) tracking system and a case management system that supports and documents all aspects of HMS’s review process and enables monitoring of activity and results by both HMS and our clients. PIE is a DB2-based system with a web-based interface that can be accessed both internally through HMS’s secure Virtual Private Network and externally through HMS’s secure eCenter Internet portal (Exhibit E-11).
HMS’s PIE System Is Accessible through Our Web-Based eCenter

PIE supports review projects for most of our clients and currently contains more than 750,000 case records and in excess of 4 million case event records. More than 300 users have secure and password-protected access rights to the system, and the system has virtually unlimited scalability. As a proprietary application, PIE is maintained by HMS’s dedicated internal Information Technology (IT) staff, which develops and implements functional upgrades on a routine basis. Accordingly, we are not dependent on external vendors to perform software maintenance or customization and can rapidly respond to DMA’s specific needs.

As a claims (data) tracking database, PIE contains all of the claims identified by HMS with potential improper payments and both current and historical claims and related data that HMS uses to perform historical analysis of our review activities and results. For example, we can generate reports by data routine, provider, or date of service.

As improper payment determinations are made, rationale and improper payment amounts from PIE will be compiled by case and forwarded to DMA for use in its recovery process (where applicable). We will generate these weekly or at a frequency specified by DMA.

Through PIE, HMS will also provide DMA and designated stakeholders with reports, transactional data, and online information regarding each claim/case identified with a potential improper payment; the status of each case (Outstanding, Received, Review Under Way, Review Complete, Case Closed); and a full history of activities, determinations, and documentation related to each case.

PIE possesses powerful functionality in the categories discussed in Exhibit E-12.
# Exhibit E-12  
**PIE Functionality and Capabilities**

<table>
<thead>
<tr>
<th>PIE Functionality Category</th>
<th>Specific Capabilities</th>
</tr>
</thead>
</table>
| **Claims/data tracking**                   | ► Contains all claims identified with potential improper payments  
► Generates claim record (down to the line level) reflecting reason for selection, over/underpayment amount as determined by DMA, review rationale, status, stage of recovery and appeal process as received from DMA, and results  
► Details full claim information, enabling accurate review, reporting, and deliverables  
► Creates on-request recovery status and activity reporting at summary and detailed levels  
► Includes standard report screens/reports and ad hoc query capability |
| **Case management**                        | ► Defines workflow and timelines for each case depending on concept  
► Enables monitoring, approval management, and QA of each workflow event  
► Automates generation of Record Request Letters (RRLs), event tracking of dates and content of letters, telephone calls, guidance  
► Allows for customized “drill-down” reporting  
► Creates electronic case file containing all documentation for each case  
► Tracks amount of overpayment  
► Tracks/sets type of review (automated, semi-automated, or complex)  
► Tracks/sets cycle or batch date |
| **Electronic case folder**                 | ► Organizes all incoming correspondence to appropriate case file  
► Houses supporting case-related documentation/notes  
► Documents written/verbal communication, including date sent or date of occurrence |
| **Web-based access**                       | Allows access via the Internet to any authorized user with a broadband connection |
| **ImageNow compatibility**                 | Links to ImageNow, HMS’s document imaging system |
| **Assignment of cases to appropriate review staff** | Assigns cases to appropriate Review staff based on various criteria/type of review (automated/semi-automated/complex) by concept type, case stage, or work queue or in a round-robin format |
| **Documentation of complex review results and rationale** | Tracks reviewer narrative and notes at claim level |
| **Documentation of over/underpayment amount** | Updates system with recovered amounts from DMA |
| **Link to HMS Provider Database**          | Provides verified provider contacts and addresses |
| **Letter generation**                      | ► Issues and saves copies of all case letters directly from the system  
► Creates Audit Notification letters  
► Adds bar codes to RRLs  
► Imports determination language  
► Generates appeal status updates from DMA  
► Enables ad hoc follow-up letters  
► Facilitates multiple, customized letter formats for each project type  
► Attaches electronic copy of all letters to case  
► Allows letters to be printable locally or mailed via HMS’s secure service center  
► Supports email or fax of letters |
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<table>
<thead>
<tr>
<th>PIE Functionality Category</th>
<th>Specific Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Include QA process prior to mailing</td>
</tr>
<tr>
<td></td>
<td>Enables optional mail and receipt date for each letter tracked</td>
</tr>
<tr>
<td></td>
<td>Mails letters to specific (verified) contacts/addresses from HMS’s Provider Database</td>
</tr>
<tr>
<td></td>
<td>Generates, prints, and sends letters in real-time on the same day</td>
</tr>
<tr>
<td>Collection management</td>
<td>Documents and maintains all payments received</td>
</tr>
<tr>
<td></td>
<td>Maintains a chronological order of all events that have occurred related to collection</td>
</tr>
<tr>
<td></td>
<td>Documents mailing dates of outgoing correspondence</td>
</tr>
<tr>
<td></td>
<td>Documents provider contacts (telephone/email log)</td>
</tr>
<tr>
<td></td>
<td>Automatically generates letters, requests, and follow-up reminders</td>
</tr>
<tr>
<td></td>
<td>Notifies staff when cases require action/follow-up in accordance with contract requirements (e.g., statute of limitations)</td>
</tr>
<tr>
<td></td>
<td>Maintains the date and time of any action taken on a case</td>
</tr>
<tr>
<td></td>
<td>Tracks cases at the workflow event/outcome level</td>
</tr>
<tr>
<td>Summary and drill-down reporting</td>
<td>Creates project recovery/activity summary, including:</td>
</tr>
<tr>
<td></td>
<td>Summary by project code (concept)</td>
</tr>
<tr>
<td></td>
<td>Summary by provider</td>
</tr>
<tr>
<td></td>
<td>Summary by date</td>
</tr>
<tr>
<td></td>
<td>Summary by project code/provider/date</td>
</tr>
<tr>
<td></td>
<td>QA reports</td>
</tr>
<tr>
<td></td>
<td>Number of cases by claim type</td>
</tr>
<tr>
<td></td>
<td>Number of open cases by program</td>
</tr>
<tr>
<td></td>
<td>Number of closed cases and reason for closing by program</td>
</tr>
<tr>
<td></td>
<td>Number of cases opened by month by program</td>
</tr>
<tr>
<td></td>
<td>Number of cases closed by month by program</td>
</tr>
<tr>
<td></td>
<td>Overpayment balance of open cases</td>
</tr>
<tr>
<td></td>
<td>Status reports</td>
</tr>
<tr>
<td></td>
<td>Exception reports</td>
</tr>
<tr>
<td></td>
<td>Number of cases assigned to each staff</td>
</tr>
<tr>
<td></td>
<td>Other reports as requested by DMA</td>
</tr>
</tbody>
</table>

Generation of FA listings and MMIS updates of claims ready for action

Creates configurable data extracts for recovery/collection activity and MMIS updates

Case search capability

Enables a variety of attributes used to search for cases

Coordination with other state recovery activity

Ensures coordination and nonduplication of efforts related to review/recovery activities

Security

Maintains extensive controls to ensure appropriate security and integrity in accordance with applicable state and federal laws and requirements

PIE Integrates with the Latest Image Technology

As we receive provider responses and documentation, we scan and post them to PIE, from which the electronic case files will be exported. All incoming letters, correspondence, medical records, and documents related to a case are scanned and indexed using bar code technology supported by manual review.

When documentation associated with a case is received, it is dated and automatically logged to the case in PIE. Reviewers can click on the document link to pull up and view the image of the document while working the case in PIE. All
documents related to the case are itemized in the Case Summary Screen and can be viewed directly from the case record. Also during this process:

► Provider telephone calls are tracked in the case contact log.
► Responses received through Provider Portal are automatically reflected in PIE.
► As responses are received, the case stage/date is updated.
► If documentation is complete, the case reviewer updates the record status and case stage.
► Cases with incomplete documentation are flagged for provider follow-up.
► Each transaction/event is tracked in the case Event Table.

**Coordination with Other Audit and Recovery Efforts**

PIE can assist DMA in coordinating all audit and recovery activity from multiple entities and vendors. Claims, providers, and even service types identified for audit by any party (e.g. Surveillance and Utilization Review Section, Medicare Fraud Control Unit) can be loaded to PIE’s exclusion tables. This will ensure that HMS’s RAC recovery efforts do not overlap with audit/recovery efforts from other state/federal agencies or vendors and will help DMA coordinate overall audit/recovery activity within the agencies. For instance, DMA-authorized users can access PIE to identify whether a particular claim, provider, or issue has been identified for audit/recovery. As we add audit populations, DMA will be able to perform consolidated reporting to monitor not only our RAC program results but also audit and recovery activity across other agencies or vendors.

Claims are loaded with a specific project code that identifies the improper payment data routine, reason for the improper payment, amount of the improper payment (if known at the time), type of review required (automated or complex), and cycle/batch date. Case status, activity, and documentation are always reflected in PIE, and each step of the review process is documented (**Exhibit E-13**).
HMS’s Case Load Process Facilitates Easy Review and Coordination of Multiple Audit Populations

As claims are loaded into PIE, the system checks them against its internal claims tracking table and various exclusion tables and criteria to ensure that excluded claims and claims that have been previously reviewed are not part of the review population. Exclusions include claims:

- Already pursued by HMS
- For services under other programs or vendors or stakeholders
- Included in a settlement population
- More than three years past the date of services (or as otherwise defined by DMA)
- With prior authorization that should be excluded (if defined by DMA)

Additional "exclusion logic" can be applied for each project to set aside claims based on DMA’s guidance, such as:

- Specific providers
- Specific program categories
- Dates of service
- Service type
- Low dollar value
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Claims identified as excluded are assigned a status of “excluded,” and the claim is assigned a status reason indicating the reason for the exclusion. Each transaction/event related to a case is tracked in the case’s event table.

**PIE Case Workflow Enables Tracking for Full Case Life Cycle**

PIE assigns cases a customizable, preset workflow to each case based on the type of improper payment (project code), and the PIE Task Screen lists all work/tasks to be completed on each case based on the case status, case stage, and previous work or events associated with the case. Workflow assignments can be customized or overridden for specific claims. For example, if a certain provider has more than a defined threshold number of record requests, the excess claims/cases can be put on hold until the provider threshold is cleared.

As clinical, financial, or pharmacy auditors review documentation for each improper payment case, they post improper payment determinations, detailed rationale, and estimated improper payment amounts (if known) related to each case in PIE. For automated improper payment cases, our Provider Outreach and Customer Service team reviews provider responses and posts provider responses to each case in PIE.

As tasks are completed, the case moves through the assigned workflow stages. HMS project managers monitor and review cases by project batch or provider or at the individual case level. We can also monitor by workflow stage and pending due date, ensuring smooth resource loading and obtaining a “big picture” view of cases and where caseloads stand relative to the full case life cycle. Every open case has at least one upcoming task associated with it until the case is closed to ensure appropriate and timely case management and follow-up.

As audit cases and their related audit case claims are approved, initiated, and move through the defined audit life cycle, PIE will track the status of each audit case file. Because PIE enables the dynamic definition of audit case workflow and case status codes for each client and each audit type, audit case status can be defined and tracked according to DMA’s requirements and preferences (Exhibit E-14). All case information will be maintained in PIE throughout the life cycle of the case and the life of the contract.
As each step of the audit process is begun or completed, audit coordinators will update PIE with the appropriate status code and status date related to each completed audit step. PIE will track the date of the entry and maintain a history of each status code, status date, and change date in the case event history table. As audit workflow events are completed, the audit case automatically moves to the next step based on the defined audit workflow approved by DMA.

Audit case status tracking will include the following case status conditions:

► Active cases:
  - Audit in progress
  - Audit awaiting provider response
  - Reaudit in progress
  - Reaudit awaiting provider response
  - Case awaiting DMA decision
  - Provider appeal
  - Audit on hold
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Closed cases:

- Repayment in progress
- Repayment complete
- Repayment uncollectible
- Recalled case

PIE Facilitates Clear Provider Communication

In a successful and comprehensive Audit program, multiple initiatives are pursued at the same time. PIE can generate notifications that include multiple project listings in a single, coordinated package, allowing us to address all improper payment issues in a coordinated manner and as efficiently as possible for DMA and its providers.

PIE enables the development of audit report templates specific to DMA’s requirements and preferences. Multiple report templates can be developed to ensure that reports reflect the data elements required for each data routine.

DMA Staff Have Access to PIE

DMA will have access to multiple report templates (Exhibit E-15). For example, a coding report would generally contain different detail than a coding error report. Reports can be printed locally in real-time or in batch via HMS’s secure service center.

Exhibit E-15 ► DMA Staff May Access Multiple Report Templates

PIE is a web-based, web-accessible system. However, to access PIE, authorized users must enter a user name and password; these unique items are specific to the user and dictate the projects or data that each user is permitted to access. The system uses the Java Cryptography Extension framework and implementations for encryption for generating
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passwords. SHA-1 (NIST FIPS 180-1) messages digest algorithms for one-way encryption of user credentials as well as the Data Encryption Standard algorithm for key-based symmetric encryption of secure user session data. Additionally, the application enforces periodic updating of user passwords for increased security.

PIE monitors and tracks all activity in real-time. The system tracks every user by the projects accessed, cases accessed, and the date/time on which the user logged in/out. HMS uses this information in our internal security reviews, and it can be made available to DMA staff to ensure that every individual accessing healthcare data is authorized to do so.

PIE Is Fully Secure
As a contractor to multiple state agencies and CMS, HMS routinely undergoes stringent testing and reviews to ensure that our systems continue to comply with state and federal requirements related to data and system security. We have an ongoing internal compliance process and annually have systems and security reviewed through an SSAE 16 Service Organization Compliance 1 Type II audit.

HMS’s Provider Portal Supporting Provider Communications
HMS will enable providers to directly access information throughout the RAC audit recovery process using our Provider Portal—a proprietary, web-based tool that provides an interface between HMS’s Provider Relations staff, our claims database, and providers. Under a different engagement with DMA, more than 2,100 North Carolina providers have registered to access our portal for TPL services. The portal for RAC services will provide similar functionality enhanced for RAC services.

The Provider Portal’s rich functionality facilitates in timely recoveries for DMA. In addition, it enhances security and privacy for the Protected Health Information that HMS receives from providers.

Benefits of the HMS Provider Portal
► Increased accuracy. A higher claim accuracy rate means fewer subsequent claims adjustments and less need for State staff intervention.
► Decreased provider abrasion. The convenience and speed of taking action and the ability to view the action taken by HMS regarding documentation submitted or claims refuted minimizes provider abrasion.
► Real-time review. Clients can access information by provider to review the status of the claims listing by provider at any time.
► Accelerated recoveries. Recovery cycles can be closed more rapidly, accelerating recoveries for clients.
► Provider self-disclosure. Providers have a web-based tool to report improper payments, reducing their administrative burden.
Providers Report Current, Accurate Contact Information to HMS

Valid contact information is essential for our Provider Relations staff to interact promptly with providers. Even when recovery processes are coordinated through the Internet, the need for telephone calls and correspondence can arise. Therefore, it is essential for HMS to have accurate provider data. **HMS has learned the limited utility of traditional methods for obtaining change-of-address and other contact information from providers.**

As an expanding hub for communication between providers and HMS, the Provider Portal functions as a central repository for collecting provider demographic data. HMS receives provider demographic data from our clients' Medicaid Information Technology System vendors on a monthly basis, and we upload those files to the portal to capture any changes from the previous file. During this time, our Provider Outreach and Customer Service team establishes initial contacts with the providers to verify their demographic data.

Providers can log in to the Provider Portal—regardless of the type of communication with HMS—and securely access their own Home Page, which posts provider summary information in a convenient location and contains an “edit” button that facilitates rapid updates to that information. Providers can take care of this basic “housekeeping” task whenever they log in to the portal. In addition, providers are directed to review and update demographic data every six months if there has been no activity on their Home Page.

**Provider Home Page**

HMS establishes a Home Page within the Provider Portal for each provider. This Home Page serves as a central “point of operations,” guiding individual providers to all of the applications available to them within the portal. After accessing the portal by entering a valid user ID and password, providers are immediately directed to their Home Page, from which they can access individual screens to update their demographic data (e.g., address and contact information). Each Home Page also identifies and provides access to any audit projects that are currently open for that provider’s response online.

**Provider Information Page**

The Provider Information Page captures basic information about the provider, including:

► Formal organization name
► Enrollment in various Healthcare programs or associations (e.g., Medicaid, Medicare Part A, National Supplier Clearinghouse, National Association of Boards of Pharmacy), and associated identification numbers
► Space for provider and HMS comments
► Summary of provider address information currently available in the Provider Portal (read only; provider must access a separate page to edit address information)
► Summary of provider contact information currently available in the Provider Portal (read only; provider must access a separate page to edit contact information)

**The Provider Portal Makes Claim Information Accessible**

HMS’s Provider Portal enables providers to view relevant member and claim data/claim listing reports. The system also enables providers to search for claims, update claim status, and ensure the accuracy of the information entered in the portal.
Other Pages

Provider Address Update Page
The Provider Address Update Page is accessible from the Provider Information Page and enables providers to designate multiple address types (e.g., general, physical) and to specify their corresponding locations. Providers must supply full address information (street address, city, state, ZIP code).

Provider Contact Update Page
The Provider Contact Update Page is accessible from the Provider Information Page and enables providers to designate multiple contact types and to identify corresponding personnel by name and primary telephone number (required fields). As an option, providers may specify additional information for each contact person, including fax number and email address.

(b) Within the 3-month implementation period, the Vendor shall provide providers with information related to the Education and Outreach Program, including: easy access to materials, data, audit policies and protocols that will be posted to support an educational program intended to reduce the amount and frequency of overpayments and underpayments. The Vendor must also send educational notifications to specific providers, such as notice that an overpayment was identified, but because it was less than $150, no recoupment will occur.

As part of the RAC program, HMS will provide education and outreach activities within the 3-month implementation period and throughout the engagement. We describe our activities in Response 3.3 below.

(c) The Vendor shall provide Program Integrity staff with full access to all audit cases for QA review, reporting and other purposes within 10 business days of full implementation of this post payment review program.

HMS affirms that we will provide Program Integrity staff with full access to all audit cases for QA review, reporting, and other purposes within 10 business days of full implementation of this Post-Payment Review program.

(d) The Vendor shall be responsible for interaction with the current, as well as the future DMA Fiscal Agent to obtain provider and recipient data from the claims processing system. The State of North Carolina is replacing the legacy MMIS with a new system, NCTracks. The replacement Fiscal Agent, CSC, is expected to begin processing NC Medicaid claims through the new NCTracks system on or about July 1, 2013. This may result in interface changes during the term of this Contract for which the Vendor shall not be compensated.

HMS will continue to interact with HP, DMA’s current FA, and we will work with CSC in the future to obtain provider and recipient data from the MMIS. HMS currently receives all the necessary data via FTP from the existing FA, thus requiring no implementation effort. Additionally, preliminary discussions have been initiated on receiving data from the future FA.

HMS MMIS Interface Capabilities

Over the past two decades, HMS has successfully interfaced with multiple MMIS installations across more than 40 states, including North Carolina. HMS operates state-of-the-art, sophisticated data processing centers in New York City and Irving, TX, where we perform all data extraction, formatting, and loading to our proprietary data warehouse. HMS’s processing hardware and operating systems are capable
of interfacing with our clients’ MMIS installations as well as systems of other healthcare payors from whom we receive data. We have developed complete functional compatibility to receive and process revenue recovery–related files from healthcare payors.

**Experience with MMIS Conversions**

HMS’s data processing expertise and our direct knowledge of North Carolina’s Medicaid environment position us to continue to deliver value to the State while placing minimal burden on DMA or the FA during the implementation process. **HMS has ample experience in maintaining our related activities during MMIS conversions, which ensures that both recoveries and cost avoidance savings are not interrupted.** In addition, to maintaining operations and recoveries, HMS often participates in the MMIS design meetings for service modules to ensure a successful conversion. Beyond informing the incoming MMIS vendor of the data files and fields critical to HMS cost containment operations, HMS will also review all data files for quality and completeness during the testing phase.

HMS is highly adept at seamlessly transitioning from one MMIS vendor to another and has successfully managed the changes required during many MMIS conversions. Because we are familiar with most MMIS file formats and processes, we can easily maintain project deliverables during the conversion process. This not only enables DMA to devote its attention to ensuring a smooth conversion but also gives DMA peace of mind knowing that results will not suffer during the conversion process and that its vendor will not charge for multiple file reformat.

**Successful Partnership with HP and CSC**

On multiple contracts, HMS has maintained an excellent working relationship with HP, the current MMIS vendor. In addition, **HMS currently works with CSC in New York.** Beyond developing relationships with the key individuals in many states, HMS has accumulated a considerable knowledge of all program integrity–related jobs and system logic that impacts the program.

Our experience in working with HP and CSC has provided us with extensive knowledge of the various MMIS data file structures and layouts that we need in order to perform accurate and timely billing on DMA’s behalf. Beyond being familiar with multiple versions of HP’s and CSC’s processing systems, **HMS is in the unique position to share MMIS best practices from other Medicaid programs.**
3.3 Assist in the Development of an Education and Outreach Program

This program will be developed through the collaborative efforts of DMA Program Integrity and the Vendor within two months of contract award. This program shall include plans for outreach efforts to associations, providers, and other stakeholders. The Vendor’s Proposal shall include suggestions of activities that will enhance an effective Education and Outreach Program that requires no less than quarterly meetings with designated provider associations and monthly postings of new or refresher information on the Vendor’s website. Under this program, the Vendor shall be responsible for:

(a) Providing outreach to notify provider communities of the RAC’s purpose and direction;
(b) Performing the necessary notification to providers of audit policies and protocols;
(c) Participating in provider association meetings and meeting with provider groups, as designated by DMA, to explain/discuss Vendor’s methodologies and results, as well as recommendations for improving provider overpayment error rates;
(d) Explaining how the provider may assist in reducing the occurrence of future overpayments and underpayments;

HMS Provider Outreach

HMS will work with DMA to develop a comprehensive Education and Outreach program within two months of contract award that will include plans for outreach efforts to associations, providers, and stakeholders. As has been part of our collaboration with DMA over the years, our intentions are always to keep all stakeholders well informed, thus minimizing abrasion and resulting in a more robust process with better buy-in. HMS’s Medicaid RAC services work plan for DMA includes outreach efforts that will educate providers regarding our services, process, and provider-friendly approach and how they benefit the Medicaid program. HMS has been successfully working with the North Carolina provider community since 1995 on DMA’s behalf.

Our ability to provide education about the program helps providers gain a better understanding of State rules and regulations, identifies common ground for improvement, strengthens our credibility, and enables us to cultivate an environment of mutual trust and respect. This outreach also enables provider stakeholder understanding and prevents abrasion that can result when providers have little or no notice of the reviews.

HMS understands that direct interaction with providers can enhance overall understanding and cooperation for achieving North Carolina’s program goals. With communication and education, providers will support Medicaid policies, communicate regularly with our team, and promote evidence-based interventions.

We recognize that communication with hospitals, physicians, nursing facilities, community service providers, other provider associations, and Medicaid contractors is critical to building good provider relationships and minimizing abrasion. Once effective working relationships are established, a multifaceted program can educate and update providers on the process for each audit.

Prior to conducting audits, HMS will implement a DMA-approved provider orientation initiative that will reach out to North Carolina provider associations as well as individual providers (through association meetings and webinars) and will ensure that providers have a clear understanding of the project’s objectives and process. With DMA’s approval, the HMS orientation process will provide an ongoing forum for dialogue between providers and HMS staff related to the project.
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A successful Review program incorporates provider input that is reflected in a decrease in each provider’s denial rate for improper documentation and billing and frequently correlates with an increased quality of care. This also leads to the providers’ greater understanding of the rules and regulations surrounding admissions to acute hospitals and ongoing care in provider facilities, which helps to ensure that a state spends its dollars appropriately and wisely.

HMS has multiple interactions with the provider community each year. Our staff is aware of key resources throughout large inpatient hospitals. Our database of provider contact information extends beyond the Chief Financial Officer to include patient account directors. We will incorporate additional contacts within each North Carolina facility, such as medical documentation experts, which will help to ensure that our communications are direct and not lost within a large facility’s mailroom.

Through our experience in North Carolina and across Medicaid programs, HMS understands that positive provider relations are critical in the successful implementation of a large-scale Provider Audit program, and we propose to begin Outreach programs to providers and other Medicaid contractors upon award of this engagement. Initially, we plan to reach out to provider associations to describe our business, purpose, and the process that we will follow to accomplish the objectives set forth by CMS and DMA guidelines. The scope of work will be defined by HMS and approved by DMA. We also plan to reach out to the provider associations at the end of each audit year and provide trending results to date. We will present an overview of the audits, their results, and plans for the next audits and answer questions regarding our process; we will refer all other questions to DMA.

Please see our draft Outreach plan components in Exhibit E-16 for an overview of how we will provide effective communications, relevant educational events, and informative publications. HMS understands that this will be the basis of discussion about our approach to provider outreach.

Exhibit E-16  Draft Provider Outreach Plan Components

<table>
<thead>
<tr>
<th>Item</th>
<th>Outreach Activity</th>
<th>Information</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Meetings of Introduction</td>
<td>HMS will schedule meetings to introduce our company and discuss the purpose of the RAC and its process.</td>
<td>0–60 days</td>
</tr>
<tr>
<td>2</td>
<td>Provider Webinars</td>
<td>HMS will reach out to providers and other stakeholders and offer webinars for introduction prior to any audit activity.</td>
<td>0–60 days and regularly scheduled for ongoing information</td>
</tr>
<tr>
<td>3</td>
<td>Newsletter</td>
<td>HMS will produce a stakeholder newsletter to provide information about the RAC and its process and to answer questions related to HMS.</td>
<td>0–60 days and every quarter thereafter for the duration of the engagement</td>
</tr>
<tr>
<td>4</td>
<td>Website</td>
<td>HMS will have a public website for all RAC stakeholders for educational materials and Frequently Asked Questions (FAQs), including a link to the DMA website.</td>
<td>0–60 days and continuous</td>
</tr>
<tr>
<td>5</td>
<td>Email</td>
<td>HMS will provide a specific email address for providers/stakeholders to submit questions or comments and for an avenue to present additional information to individuals. The email will be continuously monitored and answered by HMS Provider Relations staff.</td>
<td>0–60 days and continuous</td>
</tr>
<tr>
<td>6</td>
<td>Toll-free Number</td>
<td>HMS will provide a toll-free telephone number to our Provider Relations staff to assist providers; we answer any appropriate questions and will refer all policy-specific questions to DMA.</td>
<td>0–60 days and continuous</td>
</tr>
<tr>
<td>7</td>
<td>Special Sessions</td>
<td>HMS will hold special meetings or educational forums on an as-needed basis and will invite all provider/stakeholders; these sessions can be scheduled regionally.</td>
<td>0–60 days and continuous</td>
</tr>
</tbody>
</table>
HMS’s Approach to Provider Education

HMS will deploy the following informational and communication tools and materials upon approval from DMA.

**Provider Portal**

HMS will offer providers access to our Provider Portal, an optional online portal that can serve as the primary point of contact throughout the overpayment identification process. After providers register and supply proper credentials to validate their identity, the portal will give them a broad scope of self-service options. Providers can update contact information for Medicaid billing inquiries and requests, download overpaid claims listings, and submit questions to HMS’s Provider Outreach and Customer Service team.

The Provider Portal is a critical part of HMS’s approach to preventing overpayments because it provides a channel for clear communication about the causes of the overpayments. Upon contract award and with DMA’s approval, HMS can quickly implement additional modules and RAC-specific functionality for its providers.

**Medicaid RAC–Specific Website**

HMS is paving the way by being one of the first contractors to provide a website devoted to Medicaid RACs. To help states navigate the many facets of the ACA’s requirements for RACs, we have established an information and support website at www.medicaid-rac.com. The information accessible at Medicaid-RAC.com ranges from the history of the development of Medicaid RAC requirements to an up-to-date summary of the RAC status of all states. Valuable discussions, FAQs, and online resources are also available on the website. Topics on Medicaid-RAC.com include:

- “State Activity”—includes an interactive map of state RAC activities
- “Blog”—RAC blog for related discussions
- “Legislation”—contains up-to-date CMS RAC rules and regulations
- “Considerations”—guide to states concerning RAC vendor requirements and best practices
- “FAQ”—vehicle for submitting questions and searching previous questions and answers
- “Resources”—contains useful links to CMS and other related websites
- “For Providers”—gives information to providers on what to expect from Medicaid RACs
- “Contact HMS”—gives users an avenue for sending comments or questions to HMS

Because the website is frequently updated with information as it is released, both clients and providers have found Medicaid-RAC.com to be a very useful tool in keeping up with the changing healthcare environment. States that want to keep up to date on new and changing RAC legislation can subscribe to receive alerts to critical posts on the Medicaid-RAC.com blog.

In addition to providing the Medicaid RAC website, HMS will develop a website specifically for North Carolina as we have done for our other Medicaid RAC clients (Exhibit E-17). HMS goes far beyond the CMS Final Rule requirement to maintain a website to post audit issues. We will work with North Carolina for content requirements and prior approval before posting any information, and the North Carolina website will be devoted to RAC activities occurring in North Carolina. We will implement ongoing communication processes that ensure that providers feel that their concerns and ideas are being appropriately considered and addressed. Upon approval, we envision that the North Carolina website will contain such information as:

- Issues that have been approved for audit
- An overview of DMA’s RAC program and processes
- Links to North Carolina regulations and provider manuals
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► Information about any changes in program operations
► Relevant Medicaid criteria and notification on the types of claims, diagnoses, and errors targeted for review
► Schedule of outreach events
► Recordings of webinars and outreach presentations
► Communications regarding any new procedures, system interfaces, and rules pertaining to the review process

Exhibit E-17 ► Sample Website Screenshot

By providing this information, we can reduce provider abrasion as well as future improper payments. The website should serve to help providers determine their “RAC risk.” Providers should assign a committee or an individual responsible for keeping up with RAC issues, and they can use the information on the website to prepare cases for review and to implement changes to avoid future errors. In addition, by providing specific information about our processes, the website will enhance providers’ ability to quickly and accurately respond to RAC requests.
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Newsletters
HMS publishes trends and issues encountered in our provider newsletter.

Webinars
HMS webinars reach providers who cannot access training or communication sites. These can be extremely useful in communicating new procedures, system interfaces, and rules and in introducing any other facets of a Review program.

Notification Letters
HMS’s letters contain specific information regarding errors; this is an effective tool to educate providers about proper practices.

Conference Telephone Calls
HMS conducts regular telephone calls and in-person meetings with providers and provider associations to discuss findings.

Provider Relations and Education Success
The HMS team has implemented and led more than 200 provider educational programs. We have developed collaborative provider education opportunities, conducted large-scale seminars and workshops, provided consulting sessions with individual providers to develop quality improvement plans, and convened early quality conferences. Our production of educational materials runs the gamut from clinical, topic-specific educational reference manuals and teaching guides to web-based program information and from newsletters to one-on-one consultation.

Examples of our success in establishing high-quality working relationships with provider communities include the following:

► Prior to transition from the incumbent vendor to our team for the recently awarded Massachusetts Medicaid Utilization Management contract, HMS met regularly with the client and the outgoing vendor to discuss implementation activities and obtain guidance. An informational meeting (including officers and members of the Massachusetts Hospital Association) gave the hospitals an opportunity to ask questions surrounding the new contract. By delivering provider education prior to the launch of Utilization Review activity, providers “bought in” to the project transition to allow a smooth implementation of the new contract. We recently met a second time with the association and its provider members to discuss the project’s status and opportunities to enhance processes and communications.

► The South Carolina Department of Health and Human Services awarded HMS a contract for consulting and audit services for Medicaid overpayments. As part of this contract, we work closely with providers to educate them about best practices in coding and billing Medicaid claims. HMS conducted a comprehensive provider outreach effort to educate hospitals with respect to this project—including a step-by-step, detailed report of our review process and a communication regarding specific provider expectations. We accomplished communication via a
formal presentation to approximately 120 members of the South Carolina Hospital Association; we received ample positive provider comments and feedback regarding this effort.

**HMS Attendance at Provider and Stakeholder Meetings**

It is an HMS standard practice to attend and participate in meetings of providers and/or project stakeholders on behalf of our clients. We will attend these and other meetings as requested by DMA during the contract term. HMS personnel, including our project director, will attend legislative or other governmental staff information sessions when requested by DMA.

**HMS’s Provider Relations Team**

HMS maintains a dedicated Provider Relations team focused on facilitating communications and operational transactions between DMA’s provider community and HMS. The goal of our Provider Relations team is to establish and maintain effective communication with providers while monitoring the review and recovery process. Our Provider Relations team takes a customer-service approach to their role in terms of both attitude and operations; they understand the importance of maintaining a positive relationship with providers throughout the process.

(e) Addressing issues and answering questions, as appropriate, to increase provider and provider association understanding of DMA policies and protocol;

**HMS Call Center Communications**

Supported by state-of-the-art call center technology and proprietary case management tools, our Provider Relations team ensures that the recovery process is as clear, quick, and simple as possible. The team responds to provider inquiries and questions and resolves issues that arise during the recovery period, including the following specific activities:

- Communicate with providers to ensure that the requirements and documentation are clear and understood.
- Inform providers about the time frames during which they need to respond to the claim review request.
- Supply additional information on claim records upon request.

During the response period, our Provider Relations specialists answer providers’ questions, provide supplemental data, and manage provider correspondence in a timely manner. Our call center will be staffed from 8:00 a.m. through 5:00 p.m. Eastern Time, and we will include the toll-free telephone number to reach our call center representatives in all of the correspondence that we transmit to providers.

**Provider Relations Representatives**

HMS’s qualified and experienced Provider Relations representatives will be knowledgeable of HMS’s efforts on behalf of DMA. This knowledge will include potential recovery methods and the appeal process. Representatives will have access to our case management system, thereby enabling them to efficiently access claim-specific data that will support their ability to best respond to callers’ needs. All standard answer times, hold times, and telephone message scripts will be followed by HMS and approved by DMA prior to implementation. As necessary, the staff person responsible for an overpayment that prompts a telephone call to the call center will return the call within one business day of receipt.
Prompt, Efficient Provider Relations Service via Our Call Center

HMS is proud of the quality and speed of our response to provider inquiries, as illustrated through the following statistics:

- Average number of work events processed monthly: 26,000.
- Abandon call rate: 0.5% (compared with industry standard of 3%).
- Percentage of inbound calls sent to voicemail: 0.4%. Messages left prior to 3:00 p.m. are responded to the same day, and those left after 3:00 p.m. are responded to no later than the next day.
- First call resolution rate: 98.9%.

Effective communication is an important part of a successful Post-Payment Review program. Through the HMS provider communications process, we can inform providers on the appropriate use of funds and services. The following are some of the processes that HMS has employed successfully in other state Medicaid programs and will implement for DMA upon approval:

► Provider communication:
  - Provider overpayment notification letters that contain specific information regarding errors as an effective tool to inform providers about proper practices.
  - Publish information about trends and issues identified on our website.
  - Conduct regular conference calls and face-to-face meetings with hospital and provider associations.
  - Maintain a HIPAA-compliant website for the entire program, which will enable providers to track project activity and view trend reports and other identified issues. The website will also include links to educational materials and resources.

► Provider service:
  - Ensure that all Project staff are readily available to discuss project and/or specific issues.
  - Communicate clearly with providers.
  - Respond efficiently and courteously to provider inquiries.
  - Convey respect for the provider’s viewpoint.
  - Develop and/or modify functionality on the State’s Medicaid-specific website to provide added value and utility to the State and its providers, subject to DMA’s approval.

Our ability to provide information about the DMA program, help providers gain a better understanding of State rules and regulations, and identify common ground for improvement strengthens our credibility and enables us to cultivate an environment of mutual trust and respect. PIE retains all reviewer documentation related to each case. Medical record documentation and correspondence from/to providers (including notification letters) are also scanned and maintained in the case file. As a result, evidence documentation and rationale are immediately accessible online to support inquiry or appeal processes.
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At predefined intervals—customizable to meet the needs of the State—HMS Provider Relations specialists contact the providers who have not responded with a friendly, polite reminder of upcoming due dates for a response. Additionally, they produce reports at regular intervals listing the response status of each provider in the recovery queue. These reports are reviewed by the Project Management team to develop tailored strategies, with the guidance of the State, for follow-up with nonresponsive providers.

Prior to sending any correspondence to providers, HMS’s Provider Relations team verifies the provider address from the DMA Provider File and identifies the appropriate contact at the provider for record requests. This information is maintained in the HMS Provider Portal Provider Database and is updated and reverified if the contact information changes on the DMA file. In addition, providers can update their contact information online through our Provider Portal. Prior to generating RRLs, PIE confirms that the provider information has been verified. If not, PIE generates an exception report and does not print letters for that provider.

Making Follow-up Calls to Providers

If records are not received within the time frame prescribed by DMA or if we receive incomplete information, our Provider Relations team calls the provider or submits a second request letter that PIE generates as part of the monthly request process. PIE maintains a record of every letter sent, and our Provider Relations team enters notes pertaining to any provider follow-up into PIE’s online case history log. PIE can document and report on original and additional documentation request letters sent, and the information can be sorted by provider, by date, or by case.

HMS’s Provider Relations team works with providers throughout the contract period to maintain positive working relationships and minimize provider abrasion. Establishing a constant communication flow is essential for fostering collaboration, building strong provider relationships, and ensuring a high level of provider compliance. HMS knows that developing and managing an effective Provider Relations program requires the ability to handle a large number of provider contacts—telephone, email, fax, and mail—efficiently and accurately. Our protocols include:

► Rapid response to incoming calls
► Timely return of calls and emails
► Excellent customer service and telephone etiquette skills
► Prompt review of documentation
► Providing useful, responsive information
► Prompt error correction

HMS believes that our Provider Relations team plays a critical role in ensuring the effectiveness of a recovery audit and in working with providers to help them understand how to improve their billing practices and avoid future audits. To facilitate their efforts, we have integrated several key components into our customer support model:

► We have an established call center in place for our current Medicaid contracts that will expand to accommodate the DMA services contract.
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► We have set specific performance guidelines for each Provider Relations staff member and through our QA program will ensure that exceptional customer service is achieved.

► Provider Relations staff receive specific training on Medicaid policy and regulations to understand the proper billing and payment of Medicaid claims.

► Provider Relations can use secure email to respond to questions that do not involve sensitive information in order to provide answers as quickly as possible and will abide by all HIPAA and contract requirements. We will establish internal guidelines so staff can consistently answer questions about audit review results.

► HMS uses call monitoring software to track, monitor, record, and archive all calls as well as to produce a variety of call reports.

(f) Identifying trends or aberrant provider behavior that might require an expanded educational effort; and

As part of our education and outreach efforts and as requested by DMA, HMS will identify trends or aberrant provider behavior and provide education to providers to address those issues.

(g) Perform other education and outreach tasks.

As necessary, HMS will perform other education and outreach tasks.

3.4 Identity Potential Fraud, Abuse, and Overutilization Activities

(a) The Vendor shall assist DMA Program Integrity in the identification of potential fraud, abuse and overutilization activities that require a full review. Before beginning such a review, the Vendor shall determine the level of review required by completing the following steps:

1. Collaborate with Program Integrity to verify leads;
2. Determine the time-period to be reviewed, based on Program Integrity guidelines;
3. Verify provider was correctly identified;
4. Assign a PI Case Number;
5. Verify provider’s billing activity and determine provider’s business status;
6. Review lead, using relevant NC Medicaid policies and procedures;
7. Check for outstanding actions, sanctions, existing cases, etc.;
8. Review various sources to determine levels of compliance in other areas;
9. Determine if Provider’s behavior might be indicative of potential fraud, abuse or over-utilization; and if so,
10. Proceed with review

HMS will assist DMA Program Integrity in the identification of potential fraud, abuse, and overutilization activities through the data mining and analysis activities described in Response 3.1(b). Prior to conducting review activities, HMS will determine the level of review by performing the activities described in Exhibit E-18.
<table>
<thead>
<tr>
<th>Exhibit E-18</th>
<th><strong>HMS RAC Activities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> Collaborate with Program Integrity to verify leads;</td>
<td>HMS will collaborate with Program Integrity to verify leads. When potential audit populations have been tested and verified, HMS will develop a proposal for DMA’s approval of the issue and the audit population. This proposal will contain the following:</td>
</tr>
</tbody>
</table>
| | ► Name of the audit issue and assigned PI case number  
| | ► Description of the findings  
| | ► List and description of each policy and/or regulation related to the case  
| | ► Description of the data mining criteria used to target the issue  
| | ► How the audit should be conducted (i.e., complex, automated, semi-automated)  
| | ► Time period that is included  
| | ► Estimated improper payment amount and impact on providers (number of providers, amount per provider, etc.)  
| | ► Recommendation on the type of audit/review (automatic improper payment rule, clinical review, bill audit, etc.)  
| | ► Recommendation on whether the case might be indicative of potential fraud, overutilization, or billing error  
| | ► Sample claims, with claim-specific rationale describing why each claim in the sample was chosen  
| | ► Proposed IRGs or audit protocols as appropriate |
| **2)** Determine the time-period to be reviewed, based on Program Integrity guidelines; | As part of the verification result documentation and DMA approval process, HMS will include the appropriate applicable time periods to be reviewed in our Audit Issue Proposal. |
| **3)** Verify provider was correctly identified; | HMS incorporates data analytics quality review in our processes, including a thorough review of the data elements included in the output file to ensure that the claims selected meet the edit parameters and that the correct provider type and provider was selected. Prior to mailings, HMS Provider Relations verifies provider contact information. |
| **4)** Assign a PI Case Number; | HMS will assign a PI case number based on the scheme identified by DMA. |
| **5)** Verify provider’s billing activity and determine provider’s business status; | HMS conducts provider profiling, which includes the provider’s billing history, and compares the provider with similar provider types and provider billing patterns. HMS will verify a provider’s business status through our analysis and data matching processes. |
| **6)** Review lead, using relevant NC Medicaid policies and procedures; | HMS’s Regulatory and Reimbursement Research and Development team will review and cite the appropriate state and federal regulations, reimbursement rules, and Medicaid policies in effect for the identified scenario. |
| **7)** Check for outstanding actions, sanctions, existing cases, etc.; | A critical component in complying with federal program integrity requirements is ensuring that claim payments are not made to excluded entities or individuals. By federal law (42 CFR 1001.1901), no federal Healthcare program payment may be made for any service or item that is furnished directly or indirectly by an excluded entity or directed or prescribed by an excluded physician. Additionally, external provider data can be used to target suspect providers (not officially sanctioned but with questionable activity). HMS incorporates the OIG List of Excluded Individuals and Entities and other types of provider reference/derogatory data into our Medicaid Fraud and Abuse Detection configuration. Other data sources include:  
| | ► National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (requires DMA designation and HRSA approval)  
| | ► State exclusion lists (all states available)  
| | ► State and professional licensing files  
| | ► Professional license information  
| | ► State/professional malpractice data  
| | ► Change of address/ownership |
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- Deceased provider (SSA Death Index)

We will validate provider information against these exclusion lists to identify and flag providers and their claims with identified derogatory data. HMS will also perform a match-off to ensure that the claim is not under review by the State or another entity such as the OIG.

<table>
<thead>
<tr>
<th>(8) Review various sources to determine levels of compliance in other areas;</th>
<th>In developing our IRGs, HMS relies on State and federal source authorities and clinical and coding criteria and guidelines applicable to DMA. These will be researched on contract award, and we will work with DMA to ensure that the criteria that we are using are appropriate. Some of the source authorities used by HMS in the development of our audit/review protocols will include: North Carolina State Plan; North Carolina State Code; DMA policies; DMA Administrative Rules, Milliman or InterQual Guidelines; 3M DRG Reference and Groupers; and North Carolina Medicaid Operations Manual.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9) Determine if Provider’s behavior might be indicative of potential fraud, abuse or over-utilization; and if so,</td>
<td>HMS will determine if a provider’s behavior might be indicative of potential fraud, abuse, or overutilization through our data mining and analysis activities as described herein.</td>
</tr>
<tr>
<td>(10) Proceed with review</td>
<td>Upon identification of potential fraud, abuse, or overutilization, HMS will submit relevant documentation to DMA for approval to audit/review. We will conduct automated, semi-automated, and complex review activities.</td>
</tr>
</tbody>
</table>

**HMS Methods of Review**

Using the nomenclature developed by CMS in implementing RAC process, improper payment review/audit processes can be described as automated, semi-automated, or complex:

- **Automated review.** An automated review is used for audit issues for which there is a clearly improper payment. For these issues, state policy is explicit, the claim data has all of the attributes required to determine the existence and amount of overpayment, and no review of documentation is required to validate that an improper payment exists or the amount of the improper payment. Examples of automated review issues include duplicate payments, duplicate day payments, mutually exclusive codes, and claims paid past the patient’s date of death.

- **Semi-automated review.** A semi-automated review is used either when some additional documentation or information is required from the provider but the full medical record is not needed or the provider is not required to provide the full record. For example, in some types of upcoding reviews, HMS can determine that the code billed was not correct, but the provider might be able to provide documentation to support that level of reimbursement. A semi-automated approach gives the provider the ability to provide the documentation but does not require it.

- **Complex review.** A complex review is used for issues for which there is a high likelihood of improper payment; however, further review of the medical record or other provider documentation is required to verify that the claim was improperly paid or the amount of the improper payment. Examples of complex review issues include upcoding, excess unit billing, balance bill, and appropriate utilization/place of service. To verify improper payment for these cases, HMS will request and perform an audit/review of medical records and/or other documentation.

The type of review used for each improper payment issue will be determined during the audit development process based on the issue, the available data, and DMA guidance. We describe each of these processes in more detail below.
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(b) In instances where the Vendor has established a case, certain circumstances, (such as an existing provider case under review by another audit entity) may necessitate that the Vendor discontinue the review. If this occurs, within one (1) State business day of receiving an indication from DMA that the review should be discontinued, the Vendor shall provide DMA with documentation to show that the case is no longer being pursued by the Vendor. The Vendor shall not receive payment for such a case.

HMS recognizes that there may be times when certain circumstances necessitate that we discontinue a review. As part of our implementation process and our ongoing work plan approval process, HMS will work with DMA to identify specific claim cases, populations, and prior/ongoing recovery project claims that should be excluded from our process to comply with DMA’s requests to cease action on a case or to avoid duplication of effort or provider abrasion. We can coordinate efforts as requested by DMA.

Our powerful case management system, PIE, includes functionality specifically designed to accommodate exclusion requirements and has the flexibility to automatically exclude specific claims or certain types of claims or populations on a real-time basis. PIE will also generate documentation to show that HMS is no longer pursuing the case, and we will submit that documentation to DMA, indicate the date on which we are notified to discontinue a review, and assign a detailed status code. HMS understands that we will not receive payment for such a case.

3.5 Notify the Provider of Intended Audit, Obtain Provider Records, and Conduct the Review

Before conducting an audit, based on complaints, analytic results or other leads, the Vendor shall notify the provider that the provider has failed to substantially comply with the requirements of State or federal law or regulations. (In rare instances, the Vendor will notify the provider that DMA has a credible allegation of fraud concerning the provider.) This notification shall be included in the Record Request letter that the Vendor sends to the Provider. The Vendor may obtain records by requesting that they be sent to the Vendor or, with DMA’s prior approval, by going onsite to the provider’s location to view and/or copy records. The review shall be based on the records received or copied by the Vendor.

(a) The Vendor shall notify the provider of the time period to be reviewed, as well as the matters to be reviewed, which may include medical necessity, coding, authorization or other matters.

Prior to conducting an audit and with DMA’s approval, HMS will notify a provider of noncompliance with State requirements, federal law, or regulations. HMS generates an Audit Notification letter and RRL for providers in the audit/review cycle. The Audit Notification letter identifies HMS as a contractor to DMA, discusses the authority under which we are requesting records (e.g., noncompliance with State or federal law or regulations), discusses the scope of the audit/review project and time period for performing the review, and outlines options for the provider to obtain additional information, including a toll-free telephone number directly into HMS’s Provider Relations representatives for North Carolina providers. The RRL identifies the specific medical record or other documentation required by HMS to review each claim for improper payment.

Throughout the record request process, HMS will ensure that all affected parties (i.e., HMS and the providers) adhere to North Carolina’s regulations and policies concerning medical record requests. **HMS will research and incorporate DMA-approved requirements and letter formats into this process, customizing each letter to specify request details and response instructions.**

HMS has developed our record request and intake processes through decades of experience in requesting medical records and other documentation for coding, COB, and clinical case review/audit.
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We understand the potential for this process to cause provider abrasion due to the cost and time requirements imposed on providers. Therefore, we strive to minimize this disruption through tailoring letters to request items specific to the claims on review. We are also flexible regarding requests for extensions (if permitted by program policy) and provide multiple options for submitting records (e.g., mail, fax, and electronic transmission). We encourage providers to submit records stored on a password-protect CD/DVD or secure Flash drive. If the provider has its own electronic medical record system, our IT department works directly with the provider to set up a secure process for the transfer of medical records. We have successfully established this process with a number of providers on behalf of our state agency clients.

HMS understands that there is a limit on the number of record requests that a provider can logistically process in a given time frame. We also understand that providers receive requests from other contractors and state/federal agencies. HMS routinely works with clients to structure projects so we do not overburden providers. HMS will work with DMA to develop and implement any necessary record request limits, and we will configure PIE to flag any request in excess of a provider's predefined limits.

HMS also works in other ways to make the record request process as easy and efficient as possible for providers, including:

- Maintaining the status of all record requests in our real-time Provider Portal: providers can go online at any time to see outstanding requests and to determine if HMS received submitted documentation.
- Working with providers to enable electronic record transfers.
- Working with the medical record clearinghouses that some providers use.

Exhibit E-19 provides a sample Audit Notification letter.
Date: 1/3/2012

To: Jane Doe, Manager
   ABC Hospital
   123 Street
   City, State  12345

   Provider Number: 1234567

Re: Medicaid RAC Review

Dear Medicaid Provider,

Health Management Systems, Inc. (HMS) has been assigned as >>State’s Recovery Audit Contractor (RAC). Pursuant to Section 6411 of the Patient Protection and Affordability Care Act of 2010, HMS is authorized to audit provider payments and associated financial records for Fee-For-Service and Medicaid Managed Care and to identify under and over payments and recover any overpayments made to the provider.

Attached is a list of records that have been selected for review. Please forward photocopies of the original medical records for all dates of service listed. Supporting documentation may include, but not limited to the following:

- physician encounter notes and exams
- flow sheets
- operative reports
- diagnostic results
- nursing notes
- medication administration records
- hospital admission history and physical
- discharge summary
- ER record
- physician orders and progress notes
- lab, x-ray, and pathology reports

Please submit these records within 30 calendar days of the date of this letter. Do not send original records. You may submit your records via paper, CD/DVD or through the EDI Process. For additional information on how to submit your records, please contact Provider Services at 1-800-xxxx-xxxx. Be sure to submit all documentation necessary to substantiate your billing.

For correct handling and delivery of these records, you must enclose a copy of this request letter. HMS will not be responsible for inappropriate routing of your records when a copy of our request is not attached.

If you have any questions regarding this project, please contact Provider Services at 1-800-83-9942.

Please send the requested documentation to one of the following addresses:

<table>
<thead>
<tr>
<th>Regular Mail Service</th>
<th>Overnight Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMS-&gt;State Recovery Audit Services</td>
<td>HMS-&gt;State Recovery Audit Services</td>
</tr>
<tr>
<td>Address 1</td>
<td>Address 1</td>
</tr>
<tr>
<td>Address 2</td>
<td>Address 2</td>
</tr>
</tbody>
</table>
HMS requests only records that are necessary for review. Each claim loaded to PIE has an improper payment reason code that identifies why that claim was selected for review. For each reason code, we maintain a table of documentation components required to review that type of case.

Our record requests are configurable to specify the appropriate records required for the review based on the type of issue being reviewed, which helps ensure that we request only necessary records. Upon receipt, we can quickly identify portions of the requested sections that may be missing.

**Tracking Medical Record Requests**

HMS maintains the status of all record requests online. HMS, providers, and DMA will be able to monitor the status of all requests online at all times. Our system tracks the numbers and dates of medical record requests per provider to ensure that we do not burden providers with excessive/duplicate requests. HMS will work with DMA to develop an appropriate time frame for providers to respond to record requests. If after appropriate follow-up, the provider fails to submit the...
required records, HMS will issue a technical determination of improper payment, if consistent with DMA policy and guidance.

**Receipt and Scanning of Records**

As we receive medical records and other documentation/communications, we review them for completeness, scan them into our ImageNow enterprise imaging system, and log receipt into the Provider Portal. If the record is not complete, we note it in the status of the request and notify the provider of the outstanding items. We match all documents with the correct case and load them to PIE.

(b) The Vendor shall obtain form the State’s Fiscal Agent a report of provider paid claims for the provider number and time period under review. The Vendor shall not review a claim that has a date of service that is more than thirty-six (36) months prior to the date of review.

HMS will obtain from HP and CSC (once in place as the FA) a report of provider paid claims for the provider number and time period under review. HMS will not review claims with a date of service that is more than 36 months prior to the date of review.

(c) The Vendor shall utilize sampling software to determine an appropriate sample of the provider’s paid claims that is representative of the claims paid during the time period selected for review. The software used by the Vendor must be approved by DMA.

HMS statisticians use SAS to perform data analysis in order to develop statistical models for population stratification, identify required sample sizes, generate statistically valid stratified random or cluster sample sets, and perform extrapolation based on results. Upon request, we use OIG’s RAT-STATS package.

HMS will obtain DMA approval of the software prior to use.

(d) The Vendor shall follow procedures approved by DMA’s Program Integrity to obtain from the Provider all medical/clinical, administrative and/or financial records related to the claims to be reviewed. The Vendor shall obtain and maintain these records in a manner that preserves the chain of custody.

HMS will follow DMA-approved procedures to obtain medical records and other documentation from providers. Access to medical records and provider documentation is on an “as-needed” basis. HMS maintains many security levels and upon receipt of information, we determine which level of employee qualifies as “need to know” and grant access through a central access system to the data level authorized. Access can be revoked at any time if staff move from the project; we reassess “need-to-know” access decisions regularly using established identity management protocols.

(e) The Vendor shall ensure that the number of medical records in the request will not negatively impact the provider’s ability to provide care. Therefore, DMA Program Integrity and the Vendor shall establish an agreed upon limit of record requests per provider location and type per time period. For example: no more than one hundred twenty-five (125) inpatient medical record requests for a hospital with 150 – 249 beds during a forty-five (45) day period.

HMS understands that there is a limit on the number of record requests that a provider can logistically process in a given time frame. We also understand that providers receive requests from other contractors and state/federal agencies. HMS routinely works with clients to structure projects so we do not overburden providers. HMS will work with DMA to develop
and implement any necessary record request limits, and we will configure PIE to flag any request in excess of a provider’s predefined limits.

(f) If provider has not submitted records after ten (10) business days from the date the Initial Records Request was received by the provider, a Final Records Request notice will be sent (via traceable mail) to the provider’s Accounting address noted in the Provider Eligibility file. The Vendor shall deem that a claim payment is an overpayment if medical records are not received within five (5) business days after the provider has received the second records request.

Ten business days from the date on which the Initial Records Request was received by a provider, we will send a Final Records Request notice to the provider’s accounting address (taken from the Provider Eligibility file) to remind the provider of the deadline and the options for responding. The provider will be given several options for responding to the findings, including the web address for the Provider Portal and a toll-free telephone number.

If medical records are not received within five business days after the provider has received the Final Records Request Notice, HMS will deem that the claim payment is an overpayment.

(g) The Vendor shall develop audit/review tools and instructions for approval by DMA and shall use these tools and instructions to conduct provider case reviews. The Vendor shall apply DMA Policy when conducting provider case reviews.

Audit Protocols

For each audit/review, HMS will use appropriate and valid claims audit/review methodologies and tools, customized to DMS’s requirements for the service type and improper payment issue under review. In our audit and improper payment review work for CMS and state Medicaid programs, we have extensive experience in developing and implementing a variety of audit protocols, including Generally Accepted Government Auditing Standards (GAGAS).

Our audit/review protocols for each issue are developed and executed in accordance with generally accepted clinical and auditing practices for post-payment claims review. In the development and execution of our audit protocols, we use review criteria based on DMA’s accepted standards and all applicable State regulations, policies, and practices. HMS understands that improper payment recovery data routines and review determinations must be supported by valid regulatory source authority/requirements as well as local standards of practice. We will apply the rule in effect at the time of claim submission unless regulatory authority explicitly states that a retroactive rule applies. We will cite the applicable regulatory authority in our communications with providers during the recovery process. In our design and implementation of our data routines, our National Regulatory and Reimbursement Research/Development team has access to and incorporates a full set of regulatory and medical criteria to validate the basis for the data routine and to document the source authority relevant to that routine.

Internal Review Guidelines

In the development of our audit protocols, HMS’s Policy Research team works with experts familiar with each type of improper payment issue as well as with DMA as appropriate to develop service type–specific Audit programs, error/policy
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reference matrixes, and IRGs, audit protocols that ensure that auditors use consistent guidelines in claims review, documentation, medical record abstraction, and the application of testing criteria to the services audited.

In developing our IRGs, HMS relies on state and federal source authorities and clinical and coding criteria and guidelines applicable to DMA. These will be researched on contract award, and we will work with DMA to ensure that the criteria that we are using are appropriate. Some of the source authorities used by HMS in the development of our audit/review protocols and IRGs are shown in Exhibit E-20.

Exhibit E-20 Source Authorities That HMS Will Use for DMA

<table>
<thead>
<tr>
<th>Regulatory</th>
<th>Medical/Coding Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Plan</td>
<td>Milliman Care Guidelines</td>
</tr>
<tr>
<td>State Code</td>
<td>InterQual Guidelines</td>
</tr>
<tr>
<td>DMA Policies</td>
<td>UB-04 Uniform Billing Editor</td>
</tr>
<tr>
<td>DMA Administrative Rules</td>
<td>Coding Clinic</td>
</tr>
<tr>
<td>North Carolina Medicaid Provider Manuals</td>
<td>Encoder Pro</td>
</tr>
<tr>
<td>North Carolina Medicaid Provider bulletins</td>
<td>AMA CPT Guidelines</td>
</tr>
<tr>
<td>North Carolina Medicaid Official Publications</td>
<td>ICD-9</td>
</tr>
<tr>
<td>North Carolina BOP Rules and Regulations</td>
<td>ICD-10</td>
</tr>
<tr>
<td>CFR 42</td>
<td>HCPSC reference and guidelines</td>
</tr>
<tr>
<td>Medicaid State Operations Manual</td>
<td>3M DRG Reference and Groupers</td>
</tr>
<tr>
<td>OIG Exclusion Database</td>
<td>CMS NCCI</td>
</tr>
<tr>
<td>State Exclusion Databases (various)</td>
<td>National Correct Coding Policy and Procedures</td>
</tr>
<tr>
<td>Title XIX of the Social Security Act</td>
<td>Medicare Carrier Manuals</td>
</tr>
<tr>
<td></td>
<td>Medicaid rules, regulations, and policies</td>
</tr>
<tr>
<td></td>
<td>First Databank</td>
</tr>
<tr>
<td></td>
<td>Medispan</td>
</tr>
<tr>
<td></td>
<td>NCPDP NPI reference database</td>
</tr>
<tr>
<td></td>
<td>CMS Medicaid Pharmacy Benefit Use and Reimbursement</td>
</tr>
<tr>
<td></td>
<td>FDA reference data</td>
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<td></td>
<td>DSM-IV-TR</td>
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<tr>
<td></td>
<td>HHS WinStrat</td>
</tr>
<tr>
<td></td>
<td>APC grouper</td>
</tr>
<tr>
<td></td>
<td>3M Coding/Coverage tools</td>
</tr>
<tr>
<td></td>
<td>AIS, other coding bulletins</td>
</tr>
<tr>
<td></td>
<td>Crosswalk coding reference</td>
</tr>
<tr>
<td></td>
<td>Various commercial coding publications (e.g., DRG Desk Reference, Coding Desk References, Uniform Billing Editor, Facility Guide to Interventional Radiology)</td>
</tr>
</tbody>
</table>

Previously Unused Abbreviations: APC = Ambulatory Payment Classification; ASAM = American Society of Addiction Medicine; BOP = Board of Pharmacy; DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision; NCPDP = National Council for Prescription Drug Programs; NPI = National Provider Identifier

HMS configures our IRGs based on results from our Regulatory and Reimbursement Research and Development department to ensure that our guidelines are sound and include pertinent policies and rules.

(h) The Vendor shall review the provider’s documentation to determine whether services billed were medically necessary and administratively appropriate, whether services were billed in accordance with applicable NC Medicaid coverage policies, whether services billed were correctly coded, and whether generally accepted standards of practice were followed by the provider.

HMS conducts reviews of the submitted medical records against the codes billed to evaluate the quality of the documentation and to verify that all codes billed are fully supported within the documentation and comply with all coding.
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guidelines and regulations. Identification, audit/review, documentation, case management, and evaluation constitute the five essential components of coding compliance.

HMS examines the operational issues associated with each of these components of coding compliance:

► **Identification**—identifying records with potential improper payments
► **Audit/review**—performing medical record audits/reviews and making necessary changes
► **Documentation**—documenting all findings and citing the appropriate rationale for each finding, including citations of the regulations, policies, and/or guidelines used in making the determination
► **Case management**—maintaining the medical records, case notes, letters, and audit guidelines used for each case.
► **Evaluation**—reviewing findings for each issue type to monitor for patterns and frequency

An inpatient stay is an admission to a hospital based on an evaluation of the patient using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the patient’s illness or injury and that are documented in the medical record.

An outpatient hospital stay consists of outpatient hospital services that are within a hospital’s licensure and provided to a patient who is designated as an outpatient based on an evaluation using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the patient’s illness or injury, and that are documented in the medical record.

For inpatient care, coding reviews, LOS, and medical necessity for inpatient services relate to the accuracy and completeness of the ICD-9-CM diagnosis and procedure codes used to assign the DRGs and the quality and completeness of documentation within the records to support those codes to determine payment (Exhibit E-21).

<table>
<thead>
<tr>
<th>Exhibit E-21</th>
<th>Example of Claim with Probable Coding Compliance Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Diagnosis</strong></td>
<td>807.01 Fracture one rib-closed</td>
</tr>
<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td>874.10 Open wound larynx with trachea, complicated</td>
</tr>
<tr>
<td><strong>Procedure</strong></td>
<td>31.1 Temporary tracheostomy</td>
</tr>
</tbody>
</table>

If the claim coded above was submitted for payment, it would be assigned to DRG 003 (tracheostomy except for face, mouth and neck diagnoses), with a payment weight of 18.26. The traumatic injury that necessitated the hospital admission was the complicated open wound of the larynx and trachea and not the closed rib fracture. If the complicated open wound of the larynx and trachea was the principal diagnosis, the DRG would change to DRG 012 (tracheostomy for face, mouth and neck diagnoses with CC), with a payment weight of 3.30. The original coding of the claim results in a higher payment weight because the DRG logic assumes that the tracheostomy is being performed on a patient who is in respiratory failure and needs long-term mechanical ventilation as opposed to treatment of the open wound of the larynx and trachea. The payment amount associated with the claim as originally coded would be approximately $90,000 rather than the correct amount of $12,000. Thus, this single coding error could have substantial financial consequences.
When conducting reviews, we evaluate:

- **Coding.** The coded diagnoses and procedures are evaluated to ensure that they adhere to all Coding Clinic guidelines and ICD-9-CM coding rules.

- **Clinical.** The diagnoses, procedures, age, sex, and discharge status of the patient are evaluated to ensure clinical consistency. For example, all procedures should be reviewed to ensure that there is a diagnosis present to justify the procedure.

- **Resource.** The LOS and charges are evaluated to ensure that they are consistent with the patient’s condition. For example, a patient with an acute myocardial infarction discharged alive with a one-day LOS has a high probability of having a coding compliance problem.

For details on our clinical review process, please see Response 3.5(k) below.

(i) The Vendor shall set up and maintain a separate electronic file for each provider case.

HMS will set up an electronic case file in PIE for each provider case as described in Response 3.2(a). HMS maintains an electronic case file for every potential improper payment identified. Each case record includes all records received from the provider, documentation of all audit findings, rules and/or policies that were violated, recovery, and underpayment resolution efforts.

(j) The Vendor’s proposal must describe the conditions that make it possible to extrapolate findings and the conditions that make it impossible to extrapolate findings.

An important area is the question of when extrapolation may be used. Medicare allows extrapolation only when the RAC has evidence of sustained or high level of payment error or documentation of education to the provider with respect to the issue causing the improper payment.

“The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates that before using extrapolation to determine overpayment amounts to be recovered by recoupment, offset or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error. By law, the determination that a sustained or high level of payment error exists is not subject to administrative or judicial review.”

HMS may suggest extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise only when there is a sustained or high level of payment error or documented educational intervention has failed to correct the payment error.

If the State determines that extrapolation is appropriate, HMS will develop and propose a statistical sampling and extrapolation methodology suitable to the population and any guidelines or practices that Program Integrity may have adopted. As appropriate, we will work with the State’s statistician to ensure compliance and obtain approval of our methodology.
HMS’s Medicaid RAC services are anchored by our comprehensive clinical review capabilities. HMS’s Clinical Review staff comprises nurses, certified coders, clinicians, and auditors with specialty knowledge and experience in claims review across the spectrum of Medicaid services. Our ability to apply clinical expertise to a broad set of service types and issues is a key differentiator for HMS.

Clinical Review Process

We develop our clinical review process and protocols under the direction of our Medical Director, and our Clinical Review team has access to our physician panel of more than 900 board-certified physicians, representing nearly every recognized specialty. All issues of medical necessity are reviewed and supported by appropriate medical personnel.

Recommended clinical audits may include review of:

- Inpatient coding and level of care (acute and long term)
- Outpatient reviews:
  - Laboratory and x-ray
  - Specialized outpatient therapies
- LTC (Skilled Nursing Facilities [SNFs], ICR/MRs, and Adult Care Homes) reviews

Clinical reviews result in individual claim determinations based on appropriate medical literature and clinical review judgment. We consider the entire range of available evidence, the extent and quality of supporting evidence, and the community standards of practice, and we support all of our decisions with the expertise of appropriately certified medical reviewers.

Clinical review judgment involves two steps: (1) the synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, and nursing notes) to create a longitudinal clinical picture of the patient and (2) the application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met. Staff will use clinical review judgment when making complex review determinations. Clinical review judgment does not replace poor or inadequate medical records and, by definition, is not a process that HMS can use to override, supersede, or disregard a policy requirement, including laws, regulations, state rulings, instructional memos, manual instructions, and national coverage determinations.

Clinical Review Platform

HMS’s clinical review process is supported by a software review platform that produces an abstract of medical record demographics (e.g., date of admission, discharge disposition, and other claims data elements) and guides the reviewer
through the review process while basing each review on the specific relevant IRG for the issue being reviewed. During any level of the review process, the reviewer can forward the case to a supervisor and/or physician level for consultation and/or review.

A series of secure, online screens guides reviewers through medical record abstraction, coding review, and medical necessity and coverage review. On each screen, reviewers must confirm or deny the correctness of each claim element. They must flag any denied element and enter the rationale for their determination and cannot exit from clinical review screens until they have reviewed all of the claim elements and entered the rationale for any adverse determinations.

The first step is for the reviewer to validate patient demographics and claim data elements (Exhibit E-22).

Exhibit E-22 ▶ HMS Validates Patient Demographics and Claim Data Elements

A set of codes as originally assigned is stored in the system. The system then directs the user to review the records for correct and accurate billing and coding. The auditor makes any necessary coding changes based on the IRGs and documents the rationale for each change. We send the completed set of codes assigned and rationale for each change to QA and release the claim, with all changes stored in the system. Certified coders perform this portion of the review.

After completing billing and coding review, the case moves into a clinical review (e.g., appropriate level of care). Appropriate medical personnel such as registered nurses and/or therapists/physicians perform clinical reviews. Reviewers will use DMA-designated criteria for medical necessity of inpatient services to make appropriate referrals to physician reviewers and follow the policies for denial of services considered not medically necessary. Following the IRGs and clinical review judgment guidelines, reviewers will take into consideration all of the following components:
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► Admitting diagnosis information
► Chief complaint of the patient
► Attending physician impressions at admission
► Physician notes and information after patient study
► Identification of the condition and the treatment of that specific condition
► Documentation to support the condition and ultimately the assignment of the final diagnoses

Our reviewers must document their findings and rationale, and our software model is programmed with many standardized error codes to promote consistency and aid in trend analysis. In this workflow, the system maintains copies of the code sets as originally assigned and as assigned after the audit. Maintaining versions of the codes at both points in time is essential to maintain the audit trail of compliance actions necessary for verification (Exhibit E-23).

Exhibit E-23 ► HMS Documents Findings and Rationale

As part of our clinical review process, HMS applies specialized review techniques for the various types of audits as described below.

Specialized Review Techniques

Inpatient Coding and Level of Care Reviews

HMS has extensive experience in both prospective and retroactive review of inpatient claims and has found that even in states with robust Utilization Review programs as many as 2%–4% of all claims contain coding or utilization errors resulting in overpayment.

HMS has developed sophisticated targeting of these claims through many years of clinical review. We have been successful in returning more than $50 million in overpayments annually on behalf of state Medicaid programs. Common DRG targets and findings include:

► DRG upcoding. A coding error results in a DRG assignment error.
► Inappropriate setting. Medical record documentation does not support and/or meet admission criteria.
► Reverse DRG. HMS employs supporting physician claims to identify miscoded diagnosis and procedure codes on DRG claims.
► Transfer. There was duplicate DRG payment for transfers between hospitals.
► Readmit. There was duplicate/excess payment for readmissions.
► Outlier days/charges. Medical record documentation for outlier days did not support and/or meet criteria.
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► **DRG “Frequent Flyers.”** Frequent admissions can signal non–medically necessary stays.

► **DRG/non-DRG services.** DRG reimbursement was made for non-DRG–based services (per diem)

### Outpatient Reviews

HMS will perform data analysis and claims validation for outpatient claims, including laboratory/x-ray and specialized outpatient therapies outlined in the RFP. Our review process will include the following components shown in Exhibit E-24.

#### Exhibit E-24 ▶ **HMS Review Components**

<table>
<thead>
<tr>
<th>Review Components</th>
<th>HMS Performs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT coding errors, unbundling, or fragmentation</td>
<td>✔</td>
</tr>
<tr>
<td>High-dollar outpatient visits</td>
<td>✔</td>
</tr>
<tr>
<td>Payments exceeding charges</td>
<td>✔</td>
</tr>
<tr>
<td>Surgical procedures unbundled across claims identified for collapsed billing</td>
<td>✔</td>
</tr>
<tr>
<td>Preadmission testing violations occurring within a specific time frame of an inpatient stay</td>
<td>✔</td>
</tr>
<tr>
<td>Duplicate services across claims</td>
<td>✔</td>
</tr>
<tr>
<td>Claims with multiple occurrences of the same CPT billing codes</td>
<td>✔</td>
</tr>
<tr>
<td>Outpatient claims cross-checked with associated physician claims for the same date of service</td>
<td>✔</td>
</tr>
<tr>
<td>Emergency Department coding for inappropriate levels</td>
<td>✔</td>
</tr>
<tr>
<td>Auditing of reimbursed claims for coding accuracy</td>
<td>✔</td>
</tr>
</tbody>
</table>

Because of the scope of services, volume of claims, number of providers, and high potential for improper payment as well as fraud and abuse, a focus on the billing of outpatient, surgical, physician, and other professional claim types is an important component of any improper payment recovery or program integrity initiative. Many coding audit issues are automated review issues, but in some cases, particularly for higher-cost claims, we recommend complex reviews.

HMS reviews and audits outpatient, surgical, and professional claims using a multitiered approach and a variety of expert resources. Our algorithms can identify multiple types of coding and overpayment issues related to these claim types.

In reviewing for improper payments related to professional billing, HMS’s algorithms employ a longitudinal approach that incorporates all of the patient’s claims for the episode of care. This approach enables us to identify unbundling and unit billing issues across multiple claims, evaluate professional billing compare with the facility and surgical procedure claims, and check for services billed with no corresponding surgical claim.

**Unbundled surgeries.** There are two primary forms of unbundled surgeries, unbundled surgeries performed and unbundled services associated with a surgery.

Multiple surgery, global surgery, assistant surgeon, co-surgeon, team surgeon, and bilateral procedures are all reviewed under our correct coding and surgery filters. We will review claims to determine if the charges are allowed and for proper fee reductions and consistency of coding between surgery participants.

For example, when a surgeon performs three procedures during one surgery, the procedures should be billed using Modifier 51, which will indicate that the services are related and should not be paid as three separate surgeries; instead,
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one procedure should be paid at 100%, and the subsequent procedure should be paid at 50% or 25%. Filters will flag through an edit when a modifier is not present when multiple procedures are being performed at the same time.

Global edits. Billing for follow-up services during the surgical global period can be identified by linking the claims to the historical claim for the primary surgical procedure. Payments for many surgical codes include preoperative and postoperative office visits, which are included in the cost of the bundled surgery code. When preoperative or postoperative visits are billed separately from the global surgical procedure, HMS flags them in our global edit, which is a dynamic edit that will flag claims for “adjust” or “deny” depending on what claims have been received. For example, if an office visit was already paid by the client and a later claim reveals that it should have been included in a surgery, the global edit flags the surgery claim for adjustment, deducting the price of the already paid visit from the surgery claim.

Impossible and improbable edits. Historical information is critical to identify “impossible” and “improbable” claims such as a second hysterectomy or tonsillectomy. Identification of these claims frequently leads to the identification of potential instances of fraud and results in a referral to the Medicaid Fraud Unit. Examples would include two claims for colonoscopy on the same patient on the same day or two separate claims for gallbladder removal on the same patient. In a related manner, CPT codes are examined for duplicate services on the same claim as well as on multiple claims with the same or similar date of service to identify improper duplicate claims.

Place of service. In some programs, physicians collect higher payments for services rendered in the physician’s office, a patient’s home, an ASC, a nursing facility, or another non–hospital facility compared with the same services performed in a facility setting (such as a hospital). HMS compares all claims within the episode of care to determine if the place of service on an anesthesia claim is consistent with other claims (i.e., is there an inpatient claim?).

Identifying abuse: provider scorecard. In addition to identifying specific claims with inappropriate surgical unbundling issues, HMS analytics will also identify providers with potentially abusive billing patterns. In our process, each claim is flagged with all edits identified. The cumulative analysis of these error flags is used to build a provider scorecard report for each provider relative to specific issues, such as surgical unbundling. The provider scorecard report can be configured by period (e.g., one month) and by level of error. For example, the scorecard report can be configured to show all of the providers who were flagged more than five times for surgical unbundling errors. Summary information relating to the total dollars and average amount in error are included on the scorecard report, and individual claim information can be provided for each provider.

HMS will work with DMA to determine if providers highlighted by this report should be subject to a more focused review/audit of claims. An example of potential areas of fraud and abuse is anesthesia codes billed by nonanesthesiologists and anesthesiologists who are billing nonanesthesia codes. Specific claims related to these issues can be flagged for review and cumulative results used to develop a provider scorecard report.

Our review specialists have significant experience in reviewing claims against documentation to identify coding issues that occur in these claim types. The following are examples of the various reviews:

► Billing unit review. A provider can mistakenly bill for the administered dose amount rather than by the proper billing unit. This error can result in significant overpayments if the drug is an HCD. For example, the CPT code for pegfilgrastim is J2505, 6 mg, which has a reimbursement of $2,000. If a provider gives 5 mg and bills code J2505 5 times (thinking that J2505 is per mg), he/she would be reimbursed $10,000 instead of $2,000. In some cases, it may be necessary to review records to confirm the dose ordered and given and to ensure that the dose was calculated correctly. J2505 and other HCDs are a common cause of overpayments. More than 10,000 drugs have different indications and guidelines for appropriate use, creating the potential for significant billing errors and overpayments.
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► **Upcoding.** Upcoding refers to a provider’s use of CPT codes to bill a health insurance payor (private, Medicaid, or Medicare) for providing a higher-paying service than was actually performed. A common upcoding issue is when providers incorrectly bill for a higher E&M code. Providers sometimes mistakenly choose an E&M code based on time intervals or diagnosis selection. In most cases, these methods are incorrect. E&M code assignment is based on three components: history, exam, and medical decision making. The combination of these three documentation elements drives the code that is used. As an exception, and if accurately documented, time can be used to pick a code, but it should not be used as the default.

► **NCCI edits.** Edits are in place to ensure proper coding of procedures and to identify unbundling. We use complex clinical review by registered nurses, certified coders, and board-certified physicians to identify instances of unbundling of components within a procedure when there is a more appropriate code. This could be as simple as identifying an endoscopic procedure for which the excision is unbundled from the endoscopy or coding separately for a routine surgical closure.

► **Multiple procedures.** Multiple procedures are frequently performed on the same date of service and submitted across multiple claims. A typical example would be surgery of the paranasal sinuses, which might include as many as nine or more procedures, many of them with bilateral modifiers. These complex claims require examination for issues of proper identification of the actual procedure performed; proper sequencing of multiple procedures for multiple procedure discounting; validation of modifiers for bilateral, unusual complexity, and independent procedures performed during the same operation; unbundling; and other issues. Similarly, procedures that are routinely staged may be identified by not only CPT codes but also the associated ICD code. These procedures are more likely to be unbundled.

► **Outpatient claims cross-checked with associated physician claims.** We often see claims for monitoring performed during a procedure separate from the actual procedure or anesthesia. These codes require that monitoring be performed by an individual other than the operating surgeon, and this situation must be verified. The claim for a surgical assistant must also be verified, both in terms of necessity as well as in terms of the actual role of the assistant in specific components of the procedures.

► **Near duplicate procedures.** Near duplicates can cross claims and can be for same or different provider numbers and even different provider types (such as duplicate payments to both the doctor and the facility). We have developed logic to eliminate false positives by looking at factors such as modifiers and date billed/paid and by accounting for procedures likely to be billed multiple times in a day/period. Once the false positives are removed, our coding specialists review the medical records to determine if the documentation supports the codes billed and the level, at which they were billed.

**Long Term Care/Home Care**

Long-Term Care (LTC) facilities present a unique challenge for overpayment identification and recovery. The issues that create overpayments in other provider types (appropriate admission, medical necessity issues, lack of documentation, etc.) also impact LTC facilities.

In our review of LTC (SNFs, ICR/MRs, and Adult Care Homes) and Home Health claims, our analysts target several scenarios, including the following:
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► Appropriate Admission. Individuals must meet state and federal medical necessity and eligibility requirements for admission or re-admission to a LTC facility. Failure to do so is often the cause of LTC overpayments. A physician must certify the need for admission. Nursing care must be required on a daily basis that can only be provided in the nursing facility setting on an inpatient basis under the supervision of an RN and under the general direction of a physician. A total evaluation of the resident must be made before admission to the LTC or prior to authorization of payment by Medicaid. Individuals must be screened for suspected mental illness (MI), intellectual disability (ID), or a related condition to determine if the individual’s care and treatment needs can most appropriately be met in the nursing facility or in some other setting. If the patient has an unstable medical condition, the LTC facility must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission. All documentation to support the appropriateness of admission must be available for review and support the need for admission or re-admission to a LTC facility.

► Continued Stay. Similarly, individuals must meet state and federal medical necessity requirements for continued stay in a LTC facility. The resident must be seen by a physician at least once every 30 days for the first 90 days from admission, and at least once every 60 days thereafter. A physician must certify the need for continued stay. The LTC facility must have physician orders for the resident’s immediate care and must periodically conduct a comprehensive assessment of each resident’s functional capacity (MDS). The MDS must be completed within 14 days of admission. The LTC facility must assess the resident quarterly and an annual assessment must be completed within 366 days after final completion of the most recent comprehensive resident assessment. The LTC facility must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Each resident must receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. The care must be performed by appropriate qualified persons. The LTC facility must ensure the resident does not develop pressure ulcers while in the facility; must reduce the risk of harm resulting from falls; and other patient safety/quality of care concerns. All documentation to support the appropriateness of continued stay must be available for review.

In our audits of clinical LTC services, HMS requests and reviews the following documentation from providers (where applicable):

► Resident Assessment Instrument (MDS)
► Medicaid Patient Status Notification (Form 199)
► Form XIX LTC-9 and assessment document
► PASRR screening information
► Physician certification(s)
► Physician progress notes
► Physician orders
► Rehabilitative Plan and Treatment Notes (e.g., SP, PT, and OT)
► Nurses Notes
► History and Physical
► Discharge and Transfer Summaries
► Lab Reports
► Radiology Reports

LTC facilities present a particular challenge for overpayment identification and recovery efforts and require specialized state Medicaid knowledge, processes, and systems.
HMS incorporates the specialized review techniques described above into our automated, semi-automated, and complex review processes. We describe each of these processes in more detail below.

**Automated Review Process**

In our automated review process, an analyst will examine individual claims and various metrics concerning the audit population identified by DMA. Additionally, an internal QA process reviews the population according to the QA criteria defined for the audit issue. When the audit population passes our internal QA review, the remaining steps in the process are as follows:

► HMS will generate initial Tentative Notice of Overpayment (TNO) letters/initial Audit Reports for each provider in the cycle and, if requested, submit them to DMA for approval. These packages contain the following:

  - An introduction letter identifying HMS, citing the authority under which the review is being conducted, a toll-free telephone number for the provider to call, instructions for logging in to our Provider Portal, and the options for reconsideration and appeal
  - A summary letter and listing of all findings for the provider organized by issue type
  - Detailed listings (one for each issue) that identify the specific errors found for each claim, the reason for the payment error, the related policy rule/criterion/regulation, and the amount of the improper payment

► When DMA approves the packages, HMS sends them to each provider via United Parcel Service or certified mail.

► Providers have 30–60 days (to be determined by DMA) to respond to each improper payment determination and/or provide additional information and request a reconsideration of findings. HMS reviews all additional information and reevaluates the existence of an overpayment based on the additional information. HMS's Provider Relations team works with providers through this phase to ensure that we address provider issues to minimize subsequent administrative appeals.

► If a claim is reconsidered or appealed, HMS will send a final TNO/Final Audit Report to providers after the reconsideration period, notifying them of DMA's intent to recover the improper payment. Providers have the right to request an administrative appeal, consistent with the State's administrative appeal regulations and timing.

► After cases pass the appeal response period, HMS generates the required deliverables for recovery or recoupment, consistent with DMA's approved methodology and recovery of the improper payments.

DMA can rely on HMS to meet review deadlines. HMS's review process incorporates strict protocols to ensure that we meet the deadlines set by our clients.
Semi-Automated Review Process

HMS’s semi-automated review process includes requesting and obtaining documentation (other than medical records) from providers to support potential billing error. HMS auditors review the documentation to ensure that the claim was appropriately billed. As part of the semi-automated review process, we take the following steps:

► HMS sends an initial TNO letter/initial Audit Report to each provider in the semi-automated review cycle. The notification details the improper payment and the provider’s options for response. Providers may send additional information/documentation or agree with the findings and have 30–60 days (to be determined by DMA) to respond.

► Our Provider Relations team follows up on notification letters and tracks any documentation submitted. If we receive documentation, we scan the information and attach images to the case in our PIE case management system.

► If a provider agrees with our findings, we disposition the case as Closed and initiate recovery of overpayments, per DMA protocol.

► If a provider submits additional information, our auditors review the submitted documentation, using appropriate IRGs. If we agree with the provider, we disposition the claim as Closed/Overturned. If we continue to believe that there is an overpayment, we document our findings and underlying rationale/criteria for the findings in PIE.

► Following our review of a provider’s response, HMS will send a final TNO/Final Audit Report notifying the provider of DMA's intent to recover the improper payment. Providers have the right to request an administrative appeal, consistent with the State’s administrative appeal regulations and timing.

► After cases pass the appeal response period, HMS generates the required deliverables for recovery or recoupment, consistent with DMA's approved methodology and recovery of the improper payments.

Complex Review Process

In our complex review process, HMS requests and obtains medical records from providers and our qualified Clinical, Coding, or Bill Review Audit staff, who possess expertise in a broad scope of service types and issues, review the documentation according to our approved IRGs.

In the complex review process, reviewers will determine if:

► Documentation supports that the service was provided.

► Documentation supports that the intensity of service and/or level of service was billed according to accepted clinical criteria.

► The service was medically necessary and was provided in the proper setting according to accepted clinical criteria.

► The service as documented was covered under DMA coverage policies in place on the date of service.

► The claim was accurately billed.

► The claim was accurately coded (documentation supports codes billed).

► The service was accurately documented according to DMA requirements.
The steps of the complex review process are outlined below:

► HMS sends RRLs to each provider in the complex review cycle and gives the provider 30 days to respond.

► Our Provider Relations team follows up on RRLs, makes calls to providers as needed, and tracks each record submitted. As we receive provider records, we scan them and attach images to the case in PIE.

► Our Clinical Audit team reviews each claim against the submitted records, using appropriate IRGs. We document all findings and detailed rationale/criteria for the findings in PIE.

► As appropriate, we submit clinical issues and medical necessity findings to our physician panel for review and document the reviews in PIE.

► Senior supervisors review the nurse or audit findings and document the findings in PIE.

► Improper payment amounts are determined.

► As approved by DMA, HMS generates initial TNO letters/initial Audit Reports to notify providers of the findings and the improper payment amounts identified within CMS’ 60-day time frame.

► Providers are given an opportunity to supply additional information and can request a reconsideration of findings and have 30 days (or as appropriate for DMA) to respond.

► HMS scans additional documentation into PIE and attaches it to the appropriate case. Our clinical auditors review all additional information and work closely with providers during this process to ensure that all information and issues are fully considered. We find that a focus on this phase can significantly minimize subsequent appeals.

► Following the reconsideration period, HMS will send a final TNO/Final Audit Report to providers notifying them of DMA's intent to recover the improper payment. Providers have the right to request an administrative appeal, consistent with the State's administrative appeal regulations and timing.

► After cases pass the appeal response period, HMS generates the required deliverables for recovery or recoupment, consistent with DMA's approved methodology and recovery of the improper payments.

**Types of Issues That HMS Can Review for DMA**

HMS has experience, expertise, and well-developed audit processes that span the full scope of Medicaid service types and improper payment issues. **Exhibit E-25** summarizes by service area the types of audit issues that HMS has developed for other states and might be appropriate for DMA under the RAC contract.
## Exhibit E-25  ► Types of Issues That HMS Can Review for DMA

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Examples of HMS Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>► Appropriate admission</td>
<td>► Appropriate admission. This review returns approximately $50 million each year to one state client.</td>
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<tr>
<td></td>
<td>► Inpatient coding (i.e., DRG)</td>
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<tr>
<td></td>
<td>► Bill audit</td>
<td>► Readmissions. HMS recently identified more than $67 million in potentially inappropriate readmission errors on behalf of one state.</td>
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<td></td>
<td>► Out-of-state reimbursement error</td>
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<tr>
<td></td>
<td>► Readmissions and transfers</td>
<td>► Credit balance. In 2010, HMS performed more than 4,000 Credit Balance Audits (onsite and desk) and recovered more than $110 million for clients through these audits. Many of the audits were safety net audits where another vendor was onsite at the hospital but missed the overpayment.</td>
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<tr>
<td></td>
<td>► Never events/HACs</td>
<td>► Transfer issues. HMS has recovered more than $2 million for states related to transfer issues where we reviewed episodes of care with multiple institutional providers to ensure an appropriate payment of transfer rate.</td>
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<td></td>
<td>► Duplicate/overlapping payments (multiple types)</td>
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<td></td>
<td>► Bill audit</td>
<td>► Outpatient/inpatient overlap and unbundling. In 2010, HMS recovered more than $3 million for outpatient/inpatient overlap- and unbundling-related issues. Where policy is not clear, we work with providers to help them understand the issue and the allowable and nonallowable exceptions to the rules.</td>
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<tr>
<td></td>
<td>► ESRD issues</td>
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<td></td>
<td>► HCD errors</td>
<td>► COB payment errors. HMS recovers more than $25 million annually in excess Medicaid payments where Medicare and other third parties have made a primary payment.</td>
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<tr>
<td></td>
<td>► Financial review/credit balance</td>
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<tr>
<td></td>
<td>► Medicare deductible/coinsurance errors</td>
<td>► Inappropriate billing for professional and ancillary services. To date in 2011, we have identified more than $50 million in overpayments related to upcoding of ER-based physician services on behalf of clients.</td>
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<tr>
<td></td>
<td>► Duplicate/overlapping payments</td>
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<tr>
<td></td>
<td>► Unbundling</td>
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<tr>
<td></td>
<td>► Downcoding</td>
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<tr>
<td></td>
<td>► Radiology billing errors</td>
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<td></td>
<td>► Anesthesia billing errors</td>
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<tr>
<td></td>
<td>► NCCI coding errors</td>
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<tr>
<td><strong>Outpatient</strong></td>
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<tr>
<td></td>
<td>► Bill audit</td>
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<td>► ESRD issues</td>
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<td></td>
<td>► Medicare deductible/coinsurance errors</td>
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<tr>
<td>Category</td>
<td>Description</td>
<td>Examples of HMS Success</td>
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<tr>
<td>LTC</td>
<td>Excess/duplicate days&lt;br&gt; Patient-pay underreporting&lt;br&gt; Bed hold days&lt;br&gt; Date of death&lt;br&gt; Crossover billing errors&lt;br&gt; LTC/hospice duplicate days</td>
<td>ESRD. HMS has recovered more than $25 million in ESRD-related overpayments for clients.</td>
</tr>
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<td></td>
<td>Overlapping services included in per diem rate&lt;br&gt; Financial review/credit balance&lt;br&gt; Cost report auditing</td>
<td>Cost of Care (COC). HMS recovers more than $20 million annually through LTC financial audits. The majority of recoveries are related to COC issues.</td>
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<td></td>
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<td>Duplicate day payments for LTC, hospital, and hospice days. On behalf of one client, we recovered more than $6 million duplicate payments for hospice/LTC in 2010.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Unit billing errors&lt;br&gt; Duplicate payment/early refill&lt;br&gt; Return to stock overpayments&lt;br&gt; OTB COB issues</td>
<td>In the past three years, HMS has audited claims that have totaled more than $1 billion. Some audit findings have included duplicate claims, incorrect days’ supply or quantity submitted based on physician’s direction, and early refill.</td>
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<td></td>
<td>Duplicate/excess billing&lt;br&gt; Excess supply utilization</td>
<td>Medi-Medi improper payments. Review ensures that if a period of care is being covered by Medicare, all services covered under the 60-day Medicare period of care (i.e., supplies, drugs, and therapy) are not billed and paid by Medicaid. HMS has recovered more than $10 million for one state client through our home health review and appeal process.</td>
</tr>
<tr>
<td>Home Health</td>
<td>Medi-Medi duplicate payment&lt;br&gt; COB</td>
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<tr>
<td>Professional</td>
<td>Duplicate procedure billing&lt;br&gt; Medi-Medi duplicate&lt;br&gt; Billing for services not delivered&lt;br&gt; Upcoding of E&amp;M services&lt;br&gt; Crossover duplicates&lt;br&gt; Unbundling&lt;br&gt; Global codes&lt;br&gt; Professional/technical component errors</td>
<td>Modifier errors resulting in overpayment&lt;br&gt; NCCI&lt;br&gt; Unit billing errors&lt;br&gt; Multiple/bilateral procedures/co-surgeon cost reduction assistant surgeon&lt;br&gt; Medical necessity&lt;br&gt; Place-of-service errors</td>
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<tr>
<td>Radiology/Laboratory</td>
<td>Unbundling&lt;br&gt; Duplicate&lt;br&gt; Professional/technical component errors&lt;br&gt; NCCI</td>
<td>Medically unlikely and excess billing&lt;br&gt; Upcoding&lt;br&gt; Medical necessity&lt;br&gt; Orphan lab</td>
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<th>Category</th>
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<tbody>
<tr>
<td><strong>Dental</strong></td>
<td>Upcoding</td>
<td>Medi-Medi duplicates</td>
</tr>
<tr>
<td></td>
<td>Upcoding</td>
<td>Medically unlikely</td>
</tr>
<tr>
<td></td>
<td>Duplicate billing</td>
<td>Drug service ratio</td>
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<td></td>
<td>NCCI</td>
<td>Age inappropriate</td>
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<tr>
<td></td>
<td>Split billing</td>
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<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>Duplicate billing</td>
<td>Unbundling</td>
</tr>
<tr>
<td></td>
<td>Medi-Medi duplicate billing</td>
<td>Upcoding</td>
</tr>
<tr>
<td></td>
<td>Utilization in excess of program limits</td>
<td>Rental cap issues</td>
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<tr>
<td></td>
<td>“Miscellaneous code” review</td>
<td>Services billed and not delivered</td>
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<tr>
<td><strong>Ambulance</strong></td>
<td>Duplicate billing</td>
<td>Orphan transportation</td>
</tr>
<tr>
<td></td>
<td>Medi-Medi duplicates</td>
<td>Unbundling</td>
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<tr>
<td><strong>Behavioral Health</strong></td>
<td>Excess utilization</td>
<td>Prior authorization discrepancies</td>
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<tr>
<td></td>
<td>Unit billing errors</td>
<td>Services do not match treatment plan</td>
</tr>
<tr>
<td></td>
<td>Nonqualified staff</td>
<td>Documentation issues</td>
</tr>
<tr>
<td></td>
<td>Billing for services not delivered</td>
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</tr>
<tr>
<td></td>
<td>Medical necessity issues</td>
<td></td>
</tr>
<tr>
<td><strong>Home and Community-Based Waiver Services</strong></td>
<td>Excess utilization</td>
<td>Prior authorization discrepancies</td>
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<tr>
<td></td>
<td>Unit billing errors</td>
<td>Services do not match treatment plan</td>
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<tr>
<td></td>
<td>Nonqualified staff</td>
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<td></td>
<td>Billing for services not delivered</td>
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<tr>
<td></td>
<td>Medical necessity issues</td>
<td></td>
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<tr>
<td><strong>Custom Complex Reviews</strong></td>
<td>All-payor eReview</td>
<td>Medicare Crossover</td>
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<tr>
<td></td>
<td>340b audit</td>
<td>Managed Care Premiums</td>
</tr>
</tbody>
</table>

HMS has recovered **more than $14 million** related to dental services on behalf of Medicaid agencies.

HMS’s algorithms identify rental payments in excess of capped rental limits while incorporating Medicare coverage issues.

HMS typically finds documentation errors on more than 50% of targeted claims. For our clients, HMS has found payments well in excess of these limits.

**Medicare COB/unbundling.** For dual eligibles, HMS finds ambulance transports that should be covered under the hospital ER or inpatient stay separately billed to Medicaid.

**Orphan transport.** HMS analyzes each recipient’s claims to identify transportation claims with no other medical services on that date.

HMS identified **more than $10 million** in overpayments in the first year of one behavioral health audit that we are conducting on behalf of a state Medicaid program for the following issues: nonqualified staff performing counseling, missing documentation, noncovered services, and medical necessity.

**Home-based care.** In nine months, HMS auditors identified **more than $3 million** in overpayments to Home and Community-Based Service providers in one southern Medicaid program for the following issues: missing documentation, excess hours, and noncovered services.

**All-payor eReview.** HMS is leveraging our expertise in data, TPL, COB, and audit/review to build an all-payor database for one state that tracks payments to providers by commercial carriers, Medicare (if data can
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Examples of HMS Success</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>be obtained), and Medicaid. Through this process, we can identify duplicate and excessive payments to providers. We have our first few carriers loaded and have identified <strong>more than $3 million</strong> in duplicate payments to providers who were paid in full both by Medicaid and by a private carrier.</td>
<td></td>
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<tr>
<td></td>
<td><strong>340b audit.</strong> For another state, HMS is developing a 340b audit process that uses both MMIS and point of sale data, along with external reference databases, to identify if 340b providers are billing the Medicaid program at their discount “acquisition price” (as they are supposed to do) or at their usual and customary price. One provider in the state <strong>had more than $400,000</strong> in overpayments for this issue.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Medicare crossover repricing.</strong> For another state, HMS is reprocessing Medicare COB crossover data and finding overpayments to providers as a result of MMIS system limits. HMS had initially identified these overpayments through our audits and realized that this was a large systemic issue. Working with the state, we put together a plan to develop a data analysis and provider review process to address systematically <strong>more than $5 million</strong> in overpayments. The result will be less burden on providers than if it were done through a traditional audit and a higher and faster return to the state.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Managed care premiums.</strong> HMS has been very successful in developing overpayment data routines and implementing review processes to identify and recover erroneous premium payments to managed care organizations (MCOs). We have recovered <strong>more than $20 million</strong> on behalf of state programs from these data routines, which include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Premiums paid to plans past an enrollee’s date of death</td>
<td></td>
</tr>
</tbody>
</table>
## 3.6 Sample and Extrapolate Findings

(a) Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of items is necessary in order to produce a valid sample. In a random sample, items or units are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

HMS understands DMA’s definition of sampling herein. We may propose statistical sampling and extrapolation for DMA.

(b) When performing a review of provider records for the purpose of determining accuracy of paid amounts for claims, the review should include random sampling and extrapolation of findings, when appropriate.

For audit issues in which based on initial review, there is a sustained or high level of payment error, HMS may recommend the use of statistical sampling and extrapolation if allowed by North Carolina policy for that situation and time frame.

If DMA decides that extrapolation is appropriate, HMS will develop and propose a statistical sampling and extrapolation methodology suitable to the population and any state guidelines or practices that Program Integrity may have adopted. As appropriate, we will work with the State’s statistician to ensure compliance and obtain approval of our methodology.

Under the guidance of our national audit manager, we will also develop audit protocols for DMA approval that incorporate the principles of GAGAS methodologies, including independence, supervision, objectivity, and documentation.

HMS has experience in performing GAGAS-based sampling and extrapolation audits in the Medicaid environment through our CMS Audit MIC and state program integrity contracts. The proposed sampling methodology will take into consideration the entire universe of claims and the dollar amount associated with the claims. The most important factor in successful sampling and extrapolation is ensuring the statistical validity of the sample. To ensure that statistical validity, a Masters-level statistician who has experience in estimation methods will develop the sampling method. Only after HMS has received approval by DMA will an attempt be made to extrapolate overpayments. By ensuring the statistical validity of the sample, methods for projecting the overpayment, and approval of the methodology, we are best assured of complying with all requirements for successful extrapolation and avoiding issues on appeal.

### Examples of HMS Success

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate premiums paid</td>
<td>same ID, different ID</td>
</tr>
<tr>
<td>Incorrect premium rates</td>
<td>based on recipient's aid category/dual eligible status</td>
</tr>
<tr>
<td>Fee-for-Service claims</td>
<td>paid for Health Maintenance Organization–covered services</td>
</tr>
<tr>
<td>Excess payments</td>
<td>related to Mother/Baby situations</td>
</tr>
<tr>
<td>Premiums paid</td>
<td>for out-of-state recipients</td>
</tr>
</tbody>
</table>
(c) Extrapolation is the process of estimating a value of a variable—outside of a known range—from values within a known range by assuming that the estimated value follows logically from the known values.

HMS understands DMA’s definition of extrapolation herein, and we may propose a sampling and extrapolation methodology (as described above) to the State for this engagement.

(d) The Vendor shall conduct random sampling and assess the findings by following the instructions provided in RFP Attachment F, Statistical Sampling Guidelines. These Guidelines provide the Vendor with instructions for determining under what conditions the extrapolation of findings is appropriate.

HMS has read Attachment F of the RFP, and we will follow these guidelines for statistical sampling and extrapolation as part of our operations.

3.7 Identify Over/Underpayments

(a) Overpayment and underpayments result when an improper Medicaid payment was made and should not have been made under NC Medicaid program guidelines.

HMS understands and agrees with DMA’s clarification of over/underpayments as described herein.

(b) The Vendor shall determine whether there is an overpayment by performing the activities described in RFP Sections 3.4, 3.5 or 3.6. An overpayment is the extrapolated amount or actual amounts previously paid by DMA to a provider in excess of what Medicaid should have paid for the services furnished.

HMS affirms that we will perform the activities described in RFP Sections 3.4, 3.5, and 3.6 to determine if there is an overpayment.

(c) The Vendor shall also determine whether there is an underpayment. An underpayment is comprised of those lines on a claim that should have been billed at a higher level of payment. The Vendor shall identify underpayments while performing case reviews as outlined above.

HMS affirms our understanding of DMA’s definition of underpayment. The identification of underpayments occurs through a process very similar to the identification of overpayments. In the process of conducting audits, all potential underpayments will be submitted to DMA for approval and resolution. Our approach to identifying underpayments for DMA will be based strictly on the guidance and parameters that we receive from DMA. Some states have established parameters that define the type of underpayments that would be eligible for resolution by a contractor. For example, if a contractor found through record review that a provider had failed to bill for a procedure/service, that finding would not qualify for underpayment resolution. However, a claim that had been undercoded and should have been billed at a higher rate could qualify for underpayment resolution.
Underpayment Tracking and Resolution

Claims identified for each underpayment issue will be loaded into our PIE case management system and presented to DMA for approval. HMS can resolve underpayments upon DMA request and will customize the following steps:

► For “automated” underpayment scenarios, we will send notification that HMS has identified an underpayment to the provider using the same process as for overpayment notification. Providers will have an opportunity to approve or stop the underpayment resolution process.

► For “complex” underpayment scenarios in which a record review is required to confirm underpayment, we will send a record request notification to providers using the same process as for overpayment record requests.

► We will track provider response and records related to potential underpayments in our case management system and the appropriate Clinical, Coding, or Billing Review staff will schedule the review. Staff will use the same authority, criteria, and protocols for review and validation of underpayments as they do for overpayments.

► For validated underpayments, HMS will reprice the claim/line and calculate the appropriate payment due to the provider, using the same mechanisms and infrastructure used to calculate overpayment amounts.

► For validated underpayments, on DMA approval, we will send a TNO letter to the provider detailing the underpayment.

► If the provider disagrees with our determination of an underpayment, we will defer to the billing provider’s judgment, and in our case management system, we will “close” the improper payment with a status code that indicates that the provider did not wish to pursue. We will forward all supporting documentation, including the validation from the FA, to the contract manager.

► If the provider agrees, HMS will format and transmit an appropriate adjustment transaction that will result in appropriate payment to the provider.

► HMS will track all underpayment claims and amounts and will report these to DMA monthly. We will invoice DMA at the fee or rate negotiated for underpayments identified and refunded to the respective providers.

(d) Within five (5) business days after completion of a case review, the Vendor shall notify DMA Program Integrity of its findings, using the method of communication specified by Program Integrity. Notification of underpayment findings shall occur at least monthly and shall be separated from notice of overpayment findings. Based on the experience of Medicare RACs, it is expected that overpayment recoveries shall exceed underpayment identification by an approximate 9:1 ratio. Therefore, the Vendor shall be required to provide DMA Program Integrity with an explanation whenever underpayment identification does not match this ratio.

(1) According to CMS, the following are examples of underpayments:

(A) A provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy and the provider bills for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy were provided.

(B) A diagnosis/condition was left off the Medicaid claim but appears in the medical record. Had this diagnosis or condition been listed on the Medicaid claim, a higher payment group would have been the result.

(2) According to CMS, the following is an example of what should not be considered as underpayments:

(A) The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided; however, the additional minutes do not affect the group or the price. (In this instance, the provider type is paid based on a prospective payment system that does not pay more for this additional therapy.)

(3) The Vendor shall have no obligation to accept medical records from a provider for an underpayment unless the Vendor has requested the records.
(4) The provider has no appeal rights regarding underpayments; however, the Vendor may discuss with the provider any disagreement on whether an underpayment exists.

(5) The Vendor shall not attempt to identify an underpayment for an amount that is $150 or less.

HMS affirms that we will notify DMA Program Integrity of our findings, using the method of communication specified by Program Integrity. HMS will report underpayments monthly, separate from overpayment findings. We agree with the summation of the Medicare findings and have experienced similar results in our other Medicaid RAC contracts. HMS’s system tracks all results and generates reports broken down by underpayment versus overpayment. We will report to the State if our ratio of underpayment to overpayment exceeds the State’s prescribed threshold of 9:1. HMS affirms our understanding of CMS’ example of and underpayment provided herein. We understand that we are not required to accept medical records from providers for underpayment issues unless we have requested the record. HMS also understands that there are no appeal rights regarding underpayments, and we will discuss underpayment issues with providers when necessary. HMS will not identify underpayments of $150 or less.

(d) The Vendor shall not attempt to identify underpayments or overpayments that result from cost report settlements.

HMS affirms that we will not attempt to identify underpayments or overpayments that result from cost report settlements.

### 3.8 Notify Provider of Overpayment Findings

The Vendor is expected to complete each case review and determine the amount of overpayment in less than sixty (60) days from the date of the Records Request. Within five (5) business days of completion of the case review, the Vendor shall send notification of overpayment findings to the Medicaid provider.

(a) If an overpayment is identified, the Vendor shall send to the provider a letter that conforms to the approved Program Integrity Tentative Notice of Overpayment (TNO) template. The notice, along with the adverse findings chart, the refund attachment, the appeal attachment, as well as the completed review tools shall be sent by certified/tracked mail to the provider. (See RFP Attachments G, H, and I for current TNO related document templates.)

HMS has systems and processes in place to ensure that all reviews will be completed no later than 60 days of the request for medical records. Within five business days of audit completion, HMS will send a notification of findings to the provider. Our processes include:

- Complete review of the medical records by our professional certified reviewers
- Complete and full documentation of findings or no findings
- Audit Result letters mailed via certified/tracked mail to providers
- Follow up with providers as applicable
- Conducting recovery efforts and/or providing recoupment assistance to the DMA
- Applying recoveries as appropriate and finalizing the case
- Electronic creation of the completed case file
- Making case files with findings available to DMA

Exhibit E-26 provides an estimate by provider type of the time that we anticipate will be required to complete complex reviews.
Estimated Time Frames for Completing Complex Reviews

<table>
<thead>
<tr>
<th>Task</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims analysis and vetting procedures</td>
<td>10 days</td>
<td>10 days</td>
<td>10 days</td>
</tr>
<tr>
<td>Develop audit plan for Agency review and approval</td>
<td>5 days</td>
<td>5 days</td>
<td>5 days</td>
</tr>
<tr>
<td>The following tasks are to be completed no later than 60 days from the medical records request date</td>
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<td></td>
</tr>
<tr>
<td>Mail Introductory letter, RRL, and pre-review survey*</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
</tr>
<tr>
<td>Conduct pre-review survey and entrance conference (as applicable)*</td>
<td>1 day</td>
<td>1 day</td>
<td>1 day</td>
</tr>
<tr>
<td>Perform audit*</td>
<td>27 days</td>
<td>22 days</td>
<td>22 days</td>
</tr>
<tr>
<td>Provide Audit Findings letter to Agency for approval*</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
</tr>
<tr>
<td>Conduct exit conference with provider*</td>
<td>1 day</td>
<td>1 day</td>
<td>1 day</td>
</tr>
<tr>
<td>Mail Audit Findings letter to provider (includes provider response time)*</td>
<td>22 days</td>
<td>22 days</td>
<td>22 days</td>
</tr>
<tr>
<td>Make audit findings available to the Agency*</td>
<td>1 day</td>
<td>1 day</td>
<td>1 day</td>
</tr>
<tr>
<td>Create complete electronic case file*</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
</tr>
<tr>
<td>Notify Agency of audit completion*</td>
<td>1 day</td>
<td>1 day</td>
<td>1 day</td>
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</tbody>
</table>

* Key tasks to be completed no later than 60 days from the medical records request date

(b) The TNO letter will advise the provider of the time allotted to appeal the overpayment determination. If the DHHS Hearing Office does not receive a request for reconsideration or appeal within the time frame specified in the Notice, the Vendor shall close the case and seek recovery.

HMS will present for approval a TNO letter that will advise the provider of the time allotted to appeal the overpayment determination. If the DHHS Hearing Office does not receive a request for reconsideration or appeal within the time frame specified in the Notice, HMS will close the case and seek recovery. We take the following steps in documenting our findings.

**Documentation of Findings**

Reviewers use PIE to document coding and clinical decisions, evidence, and rationale underlying our improper payment determinations. We ensure the adequate documentation of rationale and evidence through our structured review process.

As stated previously, a series of online screens guides reviewers through medical record abstraction, coding review, and medical necessity and coverage review, and they cannot exit from clinical review screens until they have reviewed all claim elements and entered the rationale for any adverse determinations. Through many years of experience in performing clinical case review and improper payment identification, HMS has found that specific and detailed rationale contributes to provider understanding and acceptance of each determination, reduces appeals, and increases the effectiveness and return rate for the project. Every complex review that results in a finding will have detailed rationale that contains:
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- Coding changes as applicable and description and listing of all regulatory support.
- Full rationale of potential improper payment that explains the decision, outlines what has happened, and indicates what should have happened in reference to the concept and the review tool utilized as appropriate. The rationale should carry over and expand on the initial identification of the vulnerability and the review process.
- Provider liability statement, including an explanation of why the provider is liable.
- Adverse findings chart
- Refund attachment
- Appeal attachment

The rationale will follow the HMS general guidelines and quality standards described below:

- The rationale must be legible and sufficiently detailed to be clearly understandable, and it must be correct in terms of grammar and punctuation. It must be courteous and contain no accusations. The rationale must include a regulatory back-up statement, the rationale, and a statement about liability. There should be a conclusion that clearly ties the decision to the regulation. All applicable regulatory documents must be cited.
- When using the term “reasonable and necessary,” we append “by Medicaid’s criteria” or “according to Medicaid regulations.” Without such a qualifier, providers can take offense to the use of the terms since they perceive that we are dictating to them what is “necessary,” e.g., telling them how to practice medicine. What we want to clarify is what Medicaid will pay for per regulation. If a provider presents a nonreimbursable service for payment, we inform the provider that Medicaid will not pay for that type of service.
- When therapy services are not performed by trained and licensed therapists or nurses, the individuals are sometimes referred to as nonprofessional or nonskilled. These terms can be easily interpreted as rude and implying unprofessional conduct or being unskilled. If such terms must be used, we place them in quotation marks, i.e., “nonprofessional” and “nonskilled.”

Our TNO letters will conform to the specifications of the TNO document templates in this RFP. In addition, we will obtain approval from DMA on adverse findings charts, refund attachments, appeal attachments, and review tool templates.

Validation of Determinations of Reviews

A key part of ensuring that our audit/review results are accurate is ensuring that each member of our Audit/Review staff maintains a high level of quality work.

Our staff QA plan includes the following steps:

- Prior to approving determinations for a cycle, selection by the senior nurse manager of a random sample of 15% of each auditor’s findings and his/her assignment of them to a senior coder/nurse for a random sample review.
- Execution of quarterly performance assessments (followed by additional training and evaluation as needed) driven by such metrics as rates of QA returns, case denials/approvals, case outcomes, and appeals.

HMS’s Medicaid RAC methodology meets CMS’ rules. We will use robust case tracking methods to ensure that overpayment findings are sent to providers within 60 calendar days.
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Completion of a peer review process to examine periodically the quality of each staff member’s work. An IRR assessment tool verifies that a reviewer’s decisions are consistent with those of other qualified reviewers, IRGs are being followed consistently, and each rationale is adequately documented.

The QA team comprises senior nurse reviewers, senior certified coders, and a Certified Professional in Health Care Quality review manager who has years of experience in coding and clinical improper payment reviews.

During the QA review, determinations are reviewed for consistency with HMS’s IRGs as well as the format and documentation of the auditor’s notes within PIE. Of particular importance is ensuring that all of the supporting regulatory references and Medicaid-sanctioned billing guidelines used to support our coding and clinical findings are located within the claims detail review. All notations, revisions, and modifications made to the claims review must be date- and time-stamped, and the name of the individual making the modification must be appended to ensure that a complete audit trail exists.

When a claim has passed through the QA process, the claim is updated with a status of QA Approved, the QA auditor’s name, and the date and time of the approval. The claim is then routed to the QA manager for final review of the file that is to be distributed to the State for review and approval.

Upon initial hire, all coders and nurse auditors are under 100% QA review for the initial 90 days of employment. During this period, every auditor must pass a 98% accuracy rating of coding and clinical reviews and meet daily production and quality standards.

The QA team performs regular IRR reviews on all Audit staff, including new auditors who have met the 90-day quality and performance standards. These reviews ensure that IRGs are being followed consistently and that the audits are being performed in accordance with HMS quality standards. The IRR review is accomplished through a random selection and review of 15% of the audit volume by our IRR panel. The results are reviewed with the team, and either the IRGs are updated or additional training is conducted.

HMS’s medical review and QA processes are well documented, along with extensive training and monitoring. HMS has developed real-time reports to provide information to managers, enabling them to understand and effectively manage staff and workflow. The primary management criteria and data that will be monitored daily for each area of the Medicaid RAC program have already been identified.

HMS applications and tools facilitate the tracking, receipt, and analysis of all written and oral correspondence and/or discussion requests, thus providing DMA with a complete audit trail. Detailed, automated process flows support timely medical review monitoring and reporting. Built-in continual time checks ensure that we consistently meet the required time frames. The automated distribution process shares the medical record review load across the team, based on the oldest received date matched to an individual reviewer’s caseloads. HMS’s system performs a time check of claims before each distribution to ensure that they are processed within the guidelines. Any claim that reaches a record receipt time frame deadline is escalated to ensure adherence to that deadline. Automatic escalation to management of any cases approaching internal timeline deadlines provides an internal quality check to ensure that client timelines will be met.

In addition to the systematic handling and management of actual medical record reviews, HMS generates periodic status reports that are sent to management. Management is apprised of and takes action to effectively and efficiently manage any workload challenges in order to meet State deadlines. All correspondence to and from providers will be maintained as
imaged documents; all aspects of each case file are maintained in their entirety and will be accessible by both HMS and DMA.

Audit strategies involve ongoing measurement, reporting, refinement, and feedback that results in a systematic identification of specific vulnerabilities. HMS’s clinical, statistical, and claims analysis leadership assesses this collection of information in relation to the contract, coverage, policy, and regulatory language to identify improper payment identification strategies. HMS tracks all appeal results for analysis and reporting. We will use the results of the appeals to analyze where process improvements or query algorithm refinement might enhance the accuracy of our results.

HMS has extensive experience in managing provider impact and uses provider impact analysis to minimize our audit’s impact on a provider’s activities. Our edits ensure that we limit our record requests, and we take additional steps to verify that we have correct provider contact and address information. HMS will ensure that provider requests are scheduled and planned, managing provider burden and ensuring success for DMA. HMS develops strict query specifications, and through this process, we prepare supporting documentation and develop key review considerations specific to a given complex review query and to confirm that the record requests list is specific to the services under review.

HMS’s contact with providers will be through letters that request medical records. It is imperative that these letters clearly demonstrate the rationale for the request as well as provide the provider with all necessary reference material (e.g., laws, regulations, and policy). To ensure that the written notification process adheres to all DMA requirements, HMS has built several compliance edits and rules specific to letter language and improper payment descriptions into our proprietary system.

(c) The Vendor shall send a copy of the TNO letter to DMA Program Integrity, as well as prepare and submit a DHHS Controller’s Office Accounts Receivable Setup form for the overpayment, following procedures established by Program Integrity and the Controller’s Office.

HMS will send a copy of the TNO letter to DMA Program Integrity and submit a DHHS Controller’s Office Accounts Receivable Setup form for the overpayment, following Program Integrity and the Controller’s Office procedures.

3.9 Assist in Recoupment/Recovery of Overpayments

To assist in the collection of overpayments, the Vendor shall establish a process to be approved by DMA within the first 60 days of contract award, whereby the Vendor shall:

(a) Collaborate with DHHS Controller’s Office and the Department of the State Treasurer to establish a lockbox for the receipt of provider payments, which will be swept into the appropriate Treasurer’s account daily.

Maximizing Results: Recovering Improper Payments for DMA

Recovering improper payments is a critical component of the success of DMA’s program, and DMA needs a partner that has a variety of well-established and proven cash collection, cash management, reconciliation, and tracking methods. HMS has extensive experience in actual collections of improper payments, including direct contact with providers and coordinating with other entities to yield significant results. Because recovery is a component of case management, we track it through our case management system, PIE. In addition, HMS has developed our “real-time” Provider Portal, a provider-friendly tool to support the provider recovery process and minimize provider burden while expediting notification and response to improper payment determinations as well as the recovery process. HMS will seek approval of our process to collect overpayments within the first 60 days of contract award.
HMS provides initial and ongoing expert support for correct payment principles and best practices. As part of our well-established provider recovery process, we:

► Generate and forward State-approved, written notification letters, which include detailed findings (e.g., overpayment errors); instructions on required actions to be taken by the provider; a documented process for appeals; related timelines; HMS’s intention to recover funds; payment instructions (including check request); and, where approved, lockbox details. Via our innovative and secure online provider relations module, providers can elect to receive these communications either in paper or electronically.

► Communicate with providers to facilitate and simplify the recovery process and resolve issues.

► Monitor provider recovery.

► Receive and process documentation from providers (remittance advices, cancelled checks, etc.).

► Create electronic images for secure archiving and efficiency.

**Calculating the Improper Payment Amount**

HMS knows the value in understanding how DMA claims are adjudicated and reimbursed as well as how subsequent claim adjustments impact the net amount paid on the claim. During the data intake and configuration phases, we will work with stakeholders to understand all of the data elements that indicate how the claim was adjudicated; priced; and, as necessary, subsequently adjusted.

PIE documents the overpayment calculation methodology used to calculate the overpayment. HMS invests considerable effort in calculating accurate improper payment amounts. Following an auditor’s determination that an improper payment has been made, HMS determines the improper payment amount based on the details of the determination and DMA reimbursement policy.

For some improper payment determinations, such as duplicate payment or unbundled services, the entire payment for the claim or line item will be in error. For other types of improper payment determinations, we will determine that the service was partially overpaid or underpaid. For example, in an upcoding situation, we may determine that the service was necessary but that the complexity of the service documented in the medical record does not meet the requirements for the level at which it was coded. As a result, an overpayment was made since a higher complexity of service generally results in higher payment. For these cases, our coders will determine the appropriate code, and we will then reprice the claim according to the appropriate fee schedule.

HMS has significant experience in repricing claims where a partial overpayment (or underpayment) has occurred, and, as an experienced Medicaid overpayment recovery contractor, HMS routinely reprices partial recovery claims to determine appropriate overpayment amounts.
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As improper payment determinations are made and improper payment amounts are determined, they are reviewed by our QA team.

As part of our project implementation process, and in the configuration process for each data routine, we will work with DMA and project stakeholders to obtain fee schedules and pricing tables/logic. We will develop, test, and implement pricing logic and tables (DRG price tables, fee schedules, and pharmacy pricing logic tables) customized specifically to DMA reimbursement methodologies. HMS understands that inappropriately repriced claims or inaccurately calculated improper payment amounts can cause issues with providers and unnecessary work for the State. Our repricing logic will be fully tested and reviewed prior to releasing any overpayment determinations to providers. In addition, our logic will include the current interest rate and apply it per DMA guidelines.

Collection and Recoupment

HMS can provide DMA with multiple methods of recovering improper payments, including:

- Recovering directly from providers by check
- Recovering directly from providers by recouping from any remaining direct payments to the providers

Whichever method DMA chooses to recover from providers, HMS can provide the data and instructions to all parties to facilitate the process.

We describe the HMS process for recoupment below:

- HMS sends the TNO letter.
- HMS can receive responses from providers through the Provider Portal, mail, or email. HMS’s Provider Relations team tracks each response in PIE, and supporting documentation sent by the provider is imaged and attached to the case.
- If the provider agrees with the improper payment, we report the information to DMA and send a recoupment letter to the provider that includes the recoupment amount and justification, appeal information, and time frames.
- If the provider disagrees with the improper payment amount, the provider may appeal the decision per DMA guidelines.
- The HMS system is updated to reflect the recoupment status of each claim.
- A provider may refund the improper payment in full, make payment arrangements with DMA, or request offset against future claims.

Establishing a Lockbox Bank Account

HMS has established a lockbox under our present contract in North Carolina. For this engagement, we will establish a lockbox exclusively for deposit of RAC recoveries, and we will bear all costs associated with maintaining that lockbox. Further, HMS will develop detailed lockbox and banking processes for the RAC engagement and will discuss and finalize these procedures during the implementation period, making adjustments as needed or desired by DMA.
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If HMS receives payment from a provider in response to DMA recoupment efforts, we will photocopy the front and back of the check and maintain the image in the appropriate case file. We will then immediately forward the check to the appropriate address. Checks received will be processed and forwarded daily according to DMA specifications. If HMS receives a check that was forwarded to DMA for processing, we will retain a copy of the check in the HMS case file. An electronic image of the check will be paired with the record and can be recalled through our case management system.

Daily Deposit Reports

HMS will provide DMA staff with a report of the daily deposits at the time of the weekly electronic funds transfer that identifies all funds received in the lockbox or through other means, such as adjustments or offsets.

In conjunction with the DMA-established lockbox, HMS’s DOC DNA is an online tool that allows the State to recall checks received by entering specific search criteria. Any check scanned into DOC DNA may be retrieved for viewing as a PDF file, along with any related documentation.

Notice of Overpayment Determination Follow-up

HMS develops strong working relationships with providers of all types throughout the country and works to minimize a provider recovery project’s impact on them through our proven processes, efficient technology, and experienced Provider Relations team. We are available to communicate with providers throughout the recovery period to streamline the recovery of claim payments. Because we validate improper payments prior to initiating recovery activities and receive provider sign-off of some audit findings, our relationship with the provider community is collaborative rather than adversarial.

HMS’s Provider Relations staff are practiced at establishing and maintaining effective communication with providers as well as monitoring the recovery process. Supported by state-of-the-art call center technology and proprietary case management tools, our Provider Relations team ensures that the recovery process is as clear, quick, and simple as possible. The team responds to provider inquiries and questions and resolves issues that arise during the recovery period, including the following specific activities:

► Communicate with providers to ensure that the requirements and documentation are clear and understood.
► Inform providers about the time frames during which they need to respond to the claim review request.
► Supply additional information on claim records upon request.

During the response period, our Provider Relations specialists answer providers’ questions, provide supplemental data, and manage provider correspondence in a timely manner.

HMS leverages our PIE case management system to monitor the provider recovery process to ensure a seamless and effective effort. At agreed-upon intervals, HMS’s Provider Relations specialists will contact the providers who have not responded with a friendly, polite reminder of the upcoming due date for a response. Additionally, Provider Relations specialists produce reports for the Project Management team at regular intervals, listing the response status of each provider in the recovery queue. The Project Management team will review these reports to develop tailored strategies, with DMA’s guidance, for follow-up with chronically nonresponsive providers. The effectiveness of our written and verbal communications and the strong working relationships that we develop with providers achieves a reduced volume of appeals.
In collaboration with the NC DHHS Controller's Office, gain access to systems and data necessary to execute collections activities; HMS, through our existing contract, works collaboratively with the NC DHHS, the Controller’s Office, and the FI to ensure that collections are handled accurately and in a timely manner. Since these relationships are already established and data exchanges are already working, we expect to be able to employ our existing processes, thus requiring in minimal start-up time for the new contract.

Ensure that Accounts Receivable (A/R) Set-up Forms are completed timely and accurately; HMS has worked closely with the NC DHHS over the past few years to ensure that A/R forms are completed accurately and in a timely manner. We are continuously working on ways for how further to improve this process to ensure that payments that are due back to the State are processed and accurately accounted for. We expect that our established processes will allow us to implement these processes with no delay.

Reconcile lockbox receipts with collections data and post all payments in Vendor's audit management accounts receivable application within 31 days of payment receipt; HMS affirms that we will reconcile lockbox receipts with collections data and post all payments in our audit management accounts receivable application within 31 days of payment receipt. As part of our existing contract, we manage multiple recovery projects for which checks that are received through the HMS’s managed lockbox are posted and reconciled to the appropriate accounts within the aforementioned time limits.

Track and report all collections to DMA on a monthly basis; As part of our standard reporting package, HMS will track and report all collections to DMA monthly.

Monitor billing activities, related to providers, with established A/R Setups and document provider offsets as they occur, posting these offsets into the Vendor’s internal system and reconciling with the Controller’s Office on a monthly basis; and HMS will monitor billing activities related to providers with established A/R Setups and document provider offsets as they occur. We will post these offsets into our internal system and reconcile with the Controller’s Office on a monthly basis. As part of our existing operations, we have established automated processes for determining whether offsets have occurred. These offset verifications can be processed in batch format, thus allowing us to quickly convert and review them for updating our internal system.

Initiate the steps necessary to document a provider as either out of business and/or bankrupt within a designated period of time during which the provider has demonstrated no billing activity. These steps shall include reporting this information to all stakeholders, including Program Integrity, the Attorney General’s Office and the Controller’s Office; HMS contacts providers to confirm receipt of the RAC audit. At this time, we learn and document if a provider is out of business or has filed bankruptcy. We will report this information to all stakeholders as necessary.
3.10 Assist with Coordinating Reviews with Other Entities

In order to minimize the negative impact on providers who are audited, it is important that the Vendor avoid situations where the Vendor and other entities are working on the same claims. Therefore, the Vendor shall assist DMA in developing protocol and means to address this potential and to exclude providers and/or claims when required.

(a) In order to prevent situations where the Vendor and another entity are working on the same claim, in collaboration with DMA Program Integrity, the Vendor shall coordinate all of its reviews with other DMA Program Integrity vendors, sub-contractors, State and Federal auditing entities, including Medicare RACs, DMA’s sister agencies and the vendors for sister agencies that review Medicaid claims, the Office of the Inspector General, as well as the MIU and any other entities that DMA may designate.

As part of our implementation process and our ongoing work plan approval process, HMS will work with DMA to identify specific claim populations or prior/ongoing recovery project claims that should be excluded from our activity in order to avoid duplication of effort and hence provider abrasion.

Through our overpayment recovery work on behalf of Medicaid agencies, HMS has become accustomed to coordinating with the multiple pre-pay and post-pay review/audit/recovery efforts that exist within a state environment. As a “safety net” vendor, we typically must ensure that we do not duplicate or repeat prior work because doing so would cause provider abrasion and unnecessary cost to the State. HMS is experienced in developing and implementing match-off and/or exclusion logic within our process, and we can exclude claim populations at several points in our identification and review process, as indicated below:

- HMS can incorporate a “match-off” file from DMA or other contractor (file from Program Integrity department containing claims, recipients, or providers that have been reviewed or are under review) to exclude specific claims from the process.
- HMS can design an automated check against DMA’s MMIS system for any recent claim adjustments/voids.
- HMS can build logic into our data algorithms to automatically exclude certain types of claims (e.g., exclude all one-day DRG claims because these are being reviewed by a prior authorization vendor).
- HMS can manually exclude claims/populations using our claims tracking system based on verbal or written instructions from DMA on review of data algorithm results.

Likewise, HMS can easily produce a work-in-progress file from PIE, which will enable other DMA agencies to avoid duplication of claims already under review or recovered by HMS. HMS is also experienced in working with federal contractors and auditors in coordinating activities within a state. We would coordinate with other auditors only at DMA’s direction.

During implementation and on an ongoing basis, HMS will work with DMA to understand current and past activities and review types being pursued by agencies within Medicaid and other contractors (i.e., other DMA Program Integrity vendors, subcontractors, state and federal auditing entities, DMA’s sister agencies, the OIG, and the Medicaid Investigations Unit). We will gain an understanding of prior review/audit/recovery activity and any recent policy/billing changes that may suggest exclusions in our data mining or claim review activities. We will ensure that findings and activity from both prior
and current work are appropriately excluded from our identification and recovery process. In addition, HMS will assist as needed to match-off cases in the Program Integrity Management System (PIMS).

(b) If the Vendor finds that a claim has been previously reviewed or is currently under review by another vendor, DMA or another agency for the same timeframe or circumstance for which the Vendor was going to conduct its audit, then the Vendor shall not review that claim.

(1) Providers and claims can be reviewed multiple times, as long as the scope of the review or the timeframe is different. If there is a question as to whether a claim is excluded by a prior review, then the Vendor may request a decision from DMA. The DMA decision on whether the claim or scope of review in question is excluded shall be final.

(2) The Vendor shall obtain case information from its own audit management system, the PI Case Tracking database, the planned PIMS system, the MIU case list or other documents and databases, as directed by Program Integrity, before opening a case or pursuing recoupment.

If HMS finds a claim that had been previously reviewed or is currently under review by another vendor, DMA, or another agency for the same timeframe or circumstance for which we were going to conduct an audit, we will not review that claim.

HMS understands that providers and claims can be reviewed multiple times as long as the scope of the review or the timeframe is different. If there is a question as to whether a claim is excluded by a prior review, HMS may request a decision from DMA.

HMS understands that we will obtain case information from our own audit management system, the Program Integrity Case Tracking database, the planned PIMS installation, the MIU case list, or other documents and databases as directed by Program Integrity before opening a case or pursuing recoupment.

### 3.11 Refer Suspected Fraud to the MIU through Program Integrity

(a) In accordance with 42 CFR 455.21, the Vendor shall ensure that all cases of suspected provider fraud discovered while performing duties under this Contract are referred through DMA Program Integrity to the North Carolina Medicaid Investigations Unit, North Carolina Department of Justice, Office of the Attorney General (MIU). Any such referral shall be in accordance with the CMS-MIG Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit, incorporated in the document entitled, “Best Practices for Medicaid Program Integrity Units’ Interactions with Medicaid Fraud Control Units”. Therefore, the Vendor shall prepare a Case Summary Report in support of its findings and forward this report to DMA Program Integrity within two (2) State Business Days of the discovery of suspected provider fraud. The report shall include the following:

1. Subject (name, Medicaid provider ID, address, provider type)
2. Source/origin of complaint
3. Date reported to State or if developed by the Vendor, the date the Vendor initiated the investigation.
4. Description of suspected intentional misconduct, with specific details including:
   - The category of service
   - Factual explanation of the allegation
   - Specific Medicaid statutes, rules, regulations, or policies violated
   - Dates of conduct.
Identification of potential fraud and abuse can arise during any component of the improper payment identification, audit, validation, and recovery services that we offer to DMA. We train our analysts and reviewers to look for these patterns and, if identified, to immediately refer the case to their supervisor and HMS’s project manager, who will inform DMA in writing of any suspected fraud within two state business days as specified in the RFP. **After referral, HMS will fully support DMA with documentation of our findings and activities regarding each referral.**

**Documented FWA Success for Ohio Attorney General’s Office**

HMS recently assigned one of our Registered Health Information Technician/Certified Coding Specialist coders to the Ohio Attorney General’s Office to provide specialty coding expertise. We reviewed more than 1,000 medical claims for various upcoding reasons. The coder re-reviewed medical records for these patients and found unsubstantiated/undocumented charges, unbundling, duplicate billing, and level upcoding, among other issues. By providing line-by-line documentation of each audited claim, the state Attorney General was able to use our documentation in the review and potential prosecution of abuse charges.

HMS will submit a Case Summary Report to DMA Program Integrity within two state business days, which will include:

- Subject (name, Medicaid provider ID, address, provider type)
- Source/origin of complaint
- Date reported to the State or, if developed by HMS, the date on which HMS initiated the investigation
- Description of suspected intentional misconduct, with specific details including:
  - The category of service
  - Factual explanation of the allegation
  - Specific Medicaid statutes, rules, regulations, or policies violated
  - Dates of conduct
- Amount paid to the provider for the past three years or during the period of the alleged misconduct, whichever is greater
- All communications between HMS and the provider concerning the conduct at issue, when available
- Contact information for HMS staff persons with practical knowledge of the workings of the relevant programs
- Sample/exposed dollar amount, when available
(b) The Vendor shall comply within one State Business Day, without charge, to requests from DMA Program Integrity for access to copies of any records and information in the possession of the Vendor and shall comply with any requests for information or records made by the MIU as the MIU determines may be useful in carrying out its responsibilities. The Vendor shall also comply within one State Business Day and without charge to all requests of the MIU for computerized data stored by the Vendor and, whenever feasible, in the format requested by the MIU.

HMS affirms that we will comply within one state business day without charge to requests from DMA Program Integrity for access to copies of any records and information in the possession of HMS and will comply with any requests for information or records made by the MIU as the MIU determines may be useful in carrying out its responsibilities. In addition, HMS will comply within one state business day without charge to all requests of the MIU for computerized data stored by HMS and, whenever feasible, in the format requested by the MIU.

(c) If MIU decides to pursue a case that is being handled by the Vendor, upon notification, the Vendor shall cease any work on the case until it receives further notice from MIU or Program Integrity.

HMS will cease work on any case that MIU decides to pursue until we receive further notice from MIU or Program Integrity.

(d) If an employee of the Vendor is called as a witness in a fraud case and is required to attend the deposition or trial, the Vendor’s employee will do so in his or her capacity as an employee of the Vendor and shall not be subject to reimbursement from the Division for any costs incurred.

HMS understands and agrees to the requirement herein.

3.12 Participate in Appeals Process

The Vendor shall take the lead, at the direction of DMA, in all appeals that arise out of the recoupment process and shall defend its review decisions on behalf of DMA. Providers are required to send all reconsideration requests to the DHHS Hearing Office, which forwards the requests to the appropriate Program Integrity contact, who forwards documents to the Vendor. Upon receipt of a request for reconsideration, the DHHS Hearing Office conducts an informal review, which may be held by telephone, in person, or as a “paper review” of the documentation. In accordance with G.S. § 150B-23(a), the provider may appeal the Hearing Office decision to the NC Office of Administrative Hearings (OAH) and may then appeal the outcome of the OAH hearing to superior court. The Vendor shall participate; i.e., defend its review findings at each level of appeal.

HMS recognizes that DMA has a legal requirement to provide due process to providers when they are notified of improper payments and related negative determinations and will work with DMA to adhere to required time frames for giving those providers an opportunity to appeal and provide additional documentation regarding a TNO letter.

HMS brings 27 years of experience in appeals for many Medicaid agencies, MCOs, health plans, and other clients, including attending or providing support through the various fair hearing, administrative hearing, presettlement, and preappeals processes. HMS will comply with all provider appeal processes defined by the State as described in the North Carolina Provider Policy Manual. We will work closely with the State to ensure that we execute the process per DMA requirements.
HMS Provides Support throughout the Appeal Process

HMS will provide support to DMA or its authorized representative throughout all levels of the appeal. We will also provide comprehensive support to the State in response to any other litigation or dispute resolution associated with our Medicaid RAC services. Appeal support will include, as appropriate:

► Preparation and submission of all supporting documentation
► Organization and presentation of references to applicable Medicaid statutes, regulations, manuals, and instructions
► Court appearances
► Hearing appearances

To comprehensively support appeals submitted from providers, HMS will apply our extensive audit finding appeal experience and resources. We understand that the goal of the appeals process is to efficiently allow an opportunity for reconsideration when a provider disagrees with the results of our overpayment analyses. We fully support providers’ right to appeal our findings if they believe that HMS has erred when reviewing submitted documentation. As appropriate, we will apply our appeals response processes and resources to support those established by DMA.

Our review managers, clinical reviewers, and Medical Director routinely participate in hearings as required. HMS is accustomed to contributing to prehearing conferences as well and will work with DMA and its attorney to meet all requirements relating to our participation in the hearing process for this contract. In addition, HMS has experience in providing witness testimony services for our clients. 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.

We recognize that providers may appeal decisions that have an adverse financial impact on their business, especially when they believe that they are in compliance with regulations. HMS agrees that a case is not closed until either the time to appeal has expired or the appeal has been finalized. We will provide ongoing support to DMA throughout the reconsideration/appeal and fair hearing processes.

HMS works to forestall and/or resolve provider reconsiderations and/or appeals prior to fair hearings by identifying all discrepancies at the claim level. We make it easy for providers to review every claim for which we identify a recovery.

HMS has achieved a low number of reconsideration and appeal requests by providing sufficient information to support our decisions and corroborating that qualified experienced personnel conducted a thorough review and that state-specific rules and regulations were applied correctly. We work with state licensure boards, State Attorneys General, and other state Legal staff and know the necessity of maintaining professional clinician and coder support throughout the lifetime of a case. Our thoroughness is a major factor contributing to our low appeal rate for all of our clients, setting us apart from our competitors and limiting the impact of recovery activities on State staff.

In conducting improper payment reviews, our professional staff provides accurate and detailed review determinations, including clinical summaries and other documentation to show why the decision was made. In cases of clinical or coding reviews, each determination letter includes the decision rationale, based on nationally recognized guidelines; state-specific rules, regulations, and practice patterns; and the best treatment evidence available. Determinations are written in clear terms that are understandable to both professional and administrative provider contacts.
In Fiscal Year (FY) 2010, we reviewed more than 12,000 records for Ohio Medicaid, with only a 16.6% reconsideration rate. Approximately 29% of those reconsiderations were reversed because the provider submitted additional information. In State FY 2010, only 138 (1.2%) of our reviews were appealed to the State, and 80% of those decisions were upheld.

For our Virginia Department of Medical Assistance Services Medicaid program, we received only seven appeal requests to 7,000 review decisions over a two-year period. We also have seen a low rate of State overturn decisions, which demonstrates that we are in line with our clients’ goals and review processes.

As a subcontractor to HealthData Insights in support of CMS’ RAC pilot project to perform Medicare post-payment reviews, only 10% of our overpayment decisions were rebutted, and the majority of the rebuttal decisions were upheld following further review. These statistics were superior to those attained by the other RAC vendors. Over the two-year span of our contract, we reviewed approximately 1,250 Florida Medicare inpatient medical records monthly for DRG error, the medical necessity of services, and the need for an inpatient stay.

**Low Appeal Volume and Low Overturn Rate**

HMS’s low appeal rates set us apart from our competitors. Our RAC audit approach results in less work for providers since our decision rationale is clearly reported and less work for the state since there are fewer issues with providers. Even in cases in which a state requests that we implement more aggressive appeal strategies and “denial management” initiatives with providers, our rate remains low.

Key aspects of the appeals process include the following:

► Stated requirements in clear language of what forms and types of documentation the provider must submit to be considered for appeal.
► Review of documentation submitted by the provider to determine if newly acquired documentation validates the claim being audited.
► Submission of a response letter to the provider, including notification of the results of the appeal.
► Working with the provider to reach a resolution of the appeal through an informal process prior to escalation to a fair hearing.
► Escalation of appeals that cannot be resolved through an informal process. HMS’s staff will be available to assist DMA with the resolution of these appeals.

(a) Paper Reviews: In a paper review, the provider submits a written narrative stating the disagreement with the Vendor’s findings. The provider may also submit copies of any documents that support its arguments. Vendor staff shall review the reconsideration request and shall prepare an appeal summary according to DMA procedures. The appeal summary shall address each of the provider’s arguments and shall be forwarded to the Program Integrity contact and to the DHHS Hearing Office.

(1) If the provider submits no new information, but the Hearing Officer reduces the original recoupment amount for this case, any Vendor contingency fee becoming due that is based on the new amount, shall be reduced by 50%. An appropriate adjustment shall be made on the Vendor’s invoice. Fees shall be paid to the Vendor only from amounts recovered.

(2) If the provider does submit new information and it results in the Hearing Officer reducing the original recoupment amount, the Vendor shall receive a contingency fee based on the reduced amount. An appropriate adjustment shall be made to the Vendor’s invoice. Fees shall be paid to the Vendor only from amounts recovered.

(b) Telephone or in person Reconsideration Review: A provider may request a telephone or in person reconsideration review before the DHHS Hearing Officer in Raleigh in lieu of a paper review. The provider may attend the review in person or via teleconference. Vendor staff must submit a summary report to the Hearing Officer before the review. This summary report
must state the reasons for the decision to deny or reduce payment of services and a description of the Vendor’s recoupment activities to date. At the review, Vendor staff shall present an oral explanation in defense of the decision to deny or reduce payment of services. Vendor staff shall be prepared to respond to arguments made by the provider and to questions posed by the Hearing Officer and the provider. The Vendor’s Administrator and review staff shall attend this informal review. If the provider submits no new information, but the Hearing Officer reduces the original recoupment amount for this case, any Vendor contingency fee becoming due that is based on the new amount shall be reduced by 50%. An appropriate adjustment shall be made to the Vendor’s invoice. Fees shall be paid to the Vendor only from amounts recovered.

(c) OAH Contested Case Hearing: A provider may appeal the results of a paper review and a telephone or personal reconsideration review hearing to OAH. A provider may also appeal directly to OAH without going through the informal hearing process. When a provider appeals to OAH, the Vendor shall:

1. Provide a complete copy of the case file, including the medical record, to DMA Program Integrity within one State Business Day;
2. Respond to the provider’s discovery requests by the deadlines specified by the Administrative Law Judge, the Rules of Civil Procedure, and the State’s attorneys;
3. Assist the State’s attorneys with responses to discovery, prepare the case for hearing; and
4. Participate in depositions and hearings in Raleigh and other locations within the State as fact witnesses and expert witnesses.

HMS understands DMA’s processes for paper reviews, telephone or in-person reconsideration reviews, and the Office of Administrative Hearings (OAH)–contested case hearings as described herein, and we will follow these procedures in performing appeal activities for DMA.

(d) Judicial Review: A provider may appeal the results of a contested case hearing to Superior Court. The Vendor shall provide technical support to the State’s attorneys during judicial review.

HMS understands that a provider may appeal the results of a contested case hearing to Superior Court. We will provide technical support to the State’s attorneys during the judicial review process.

(e) If the Vendor’s findings are overturned at the OAH level, the Vendor shall only receive a fee for the case, based on the OAH decision.

HMS understands that if findings are overturned at the OAH level, we will only receive a fee for the case, based on the OAH decision.

(f) If DMA agrees to a settlement with the provider, outside of the Appeals process, the Vendor shall only receive a fee for the case, based on the settlement amount.

If DMA agrees to a settlement with a provider outside of the appeals process, HMS will only receive a fee for the case based, on the settlement amount.