PROGRAM DESCRIPTION

Department: Social Services **HB Section(s): 11.020**
Program Name: Office of Director
Program is found in the following core budget(s): MO Medicaid Audit & Compliance (MMAC)

1a. What strategic priority does this program address?

Protect the integrity of the Missouri Medicaid program

1b. What does this program do?

- Enrolls new Medicaid providers and maintains enrollment files for approimately 65,000 health care providers that participate in the MO HealthNet fee-for-service (FFS) and managed care programs. This includes processing new applications, updating the records of existing providers, and revalidating the enrollment information for each MO HealthNet provider at least every five years. Federal regulations require screening of new applicants as well as monthly monitoring of current providers.
- Conducts audits and investigations of enrolled providers and determines appropriate enforcement activities, including education, prepayment review, restricted participation, recoupment, participation or payment suspension, or termination. Audits and investigations that identify a credible allegation of fraud are referred to the Attorney General's Office Medicaid Fraud Control Unit (MFCU).
- Performs oversight of contracted vendors conducting Electronic Health Records Incentive Payments audits, Credit Balance Audits (CBA) and Long-Term Care (LTC) audits on patient accounts, and Commercial Insurance Disallowance Audits.
- Works closely with enrolled providers to ensure they receive necessary information regarding program requirements.

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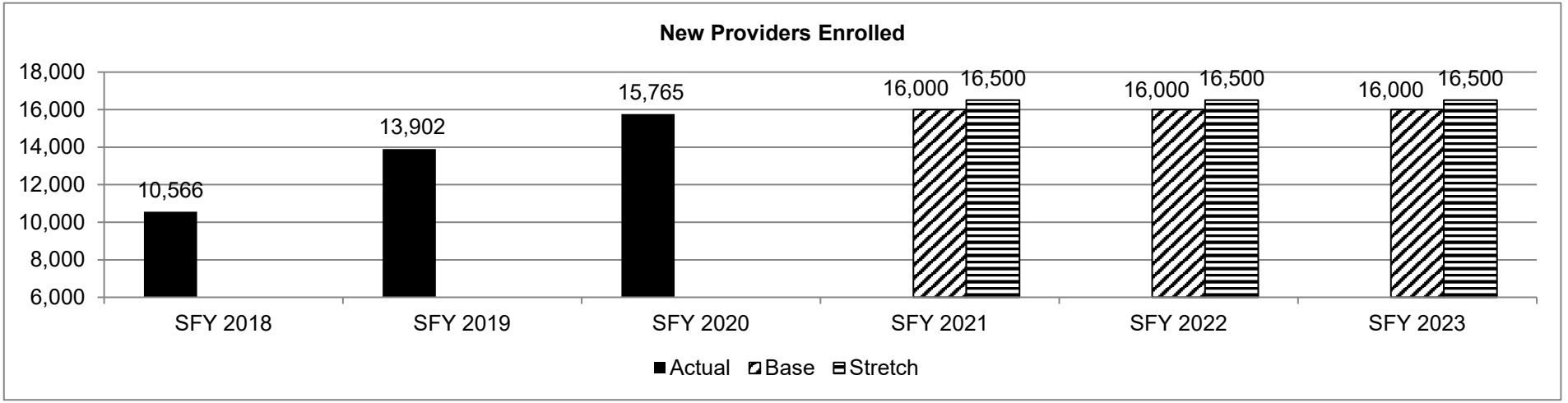
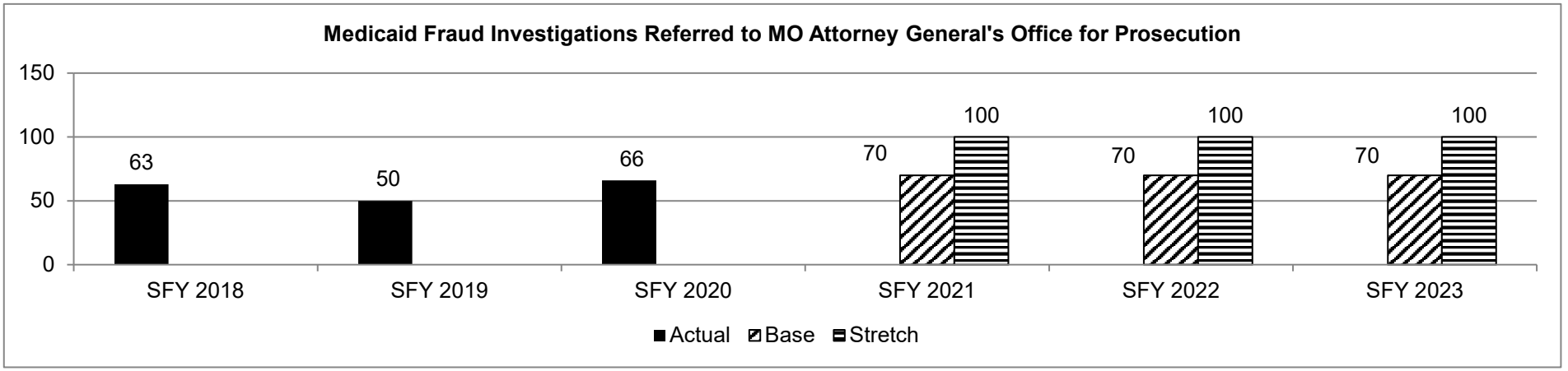
2a. Provide an activity measure(s) for the program.



2b. Provide a measure(s) of the program's quality.



MMAC Investigations resulting in a finding of "credible allegation of fraud" are referred to the Medicaid Fraud Control Unit (MFCU) at AGO for prosecution.

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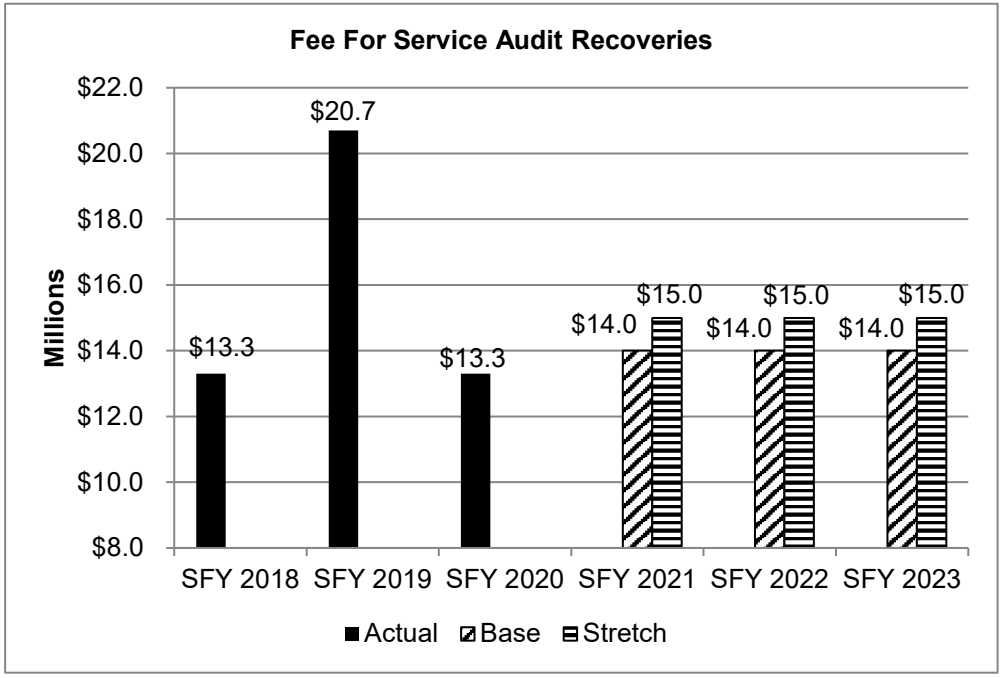
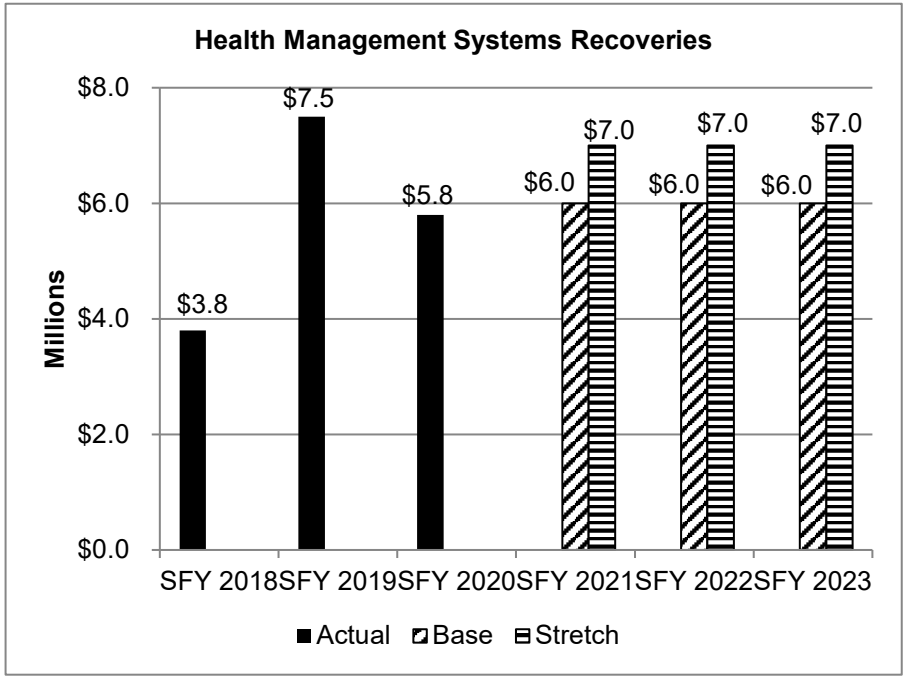
2c. Provide a measure(s) of the program's impact.





The Fee For Service audits are conducted by MMAC staff and the Health Management Systems (HMS) contractor. HMS is a contractor employed by MMAC to conduct Long Term Care, Credit Balance, and Commercial Insurance Disallowance audits.

Department: Social Services **HB Section(s): 11.020**
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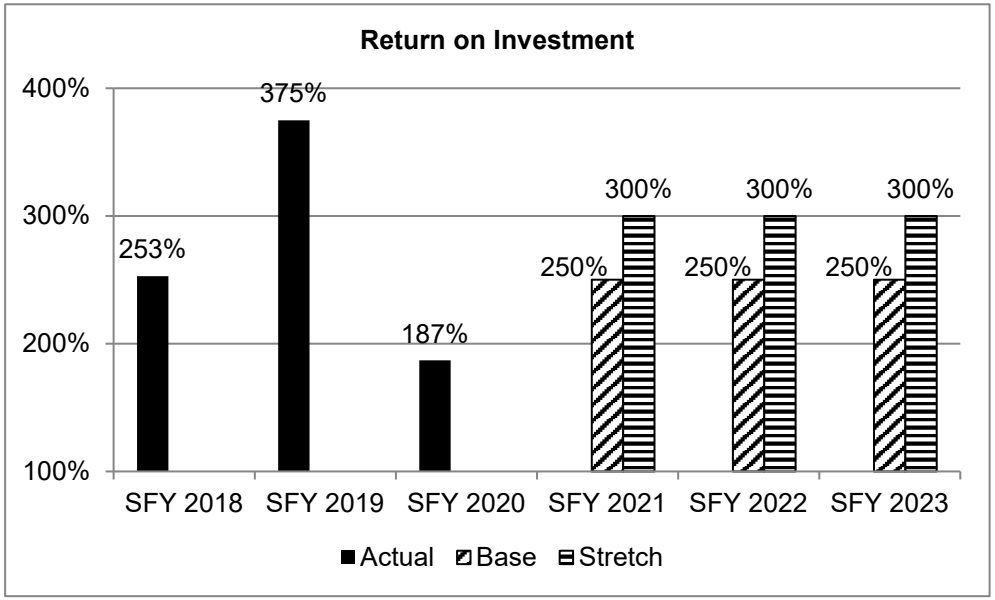
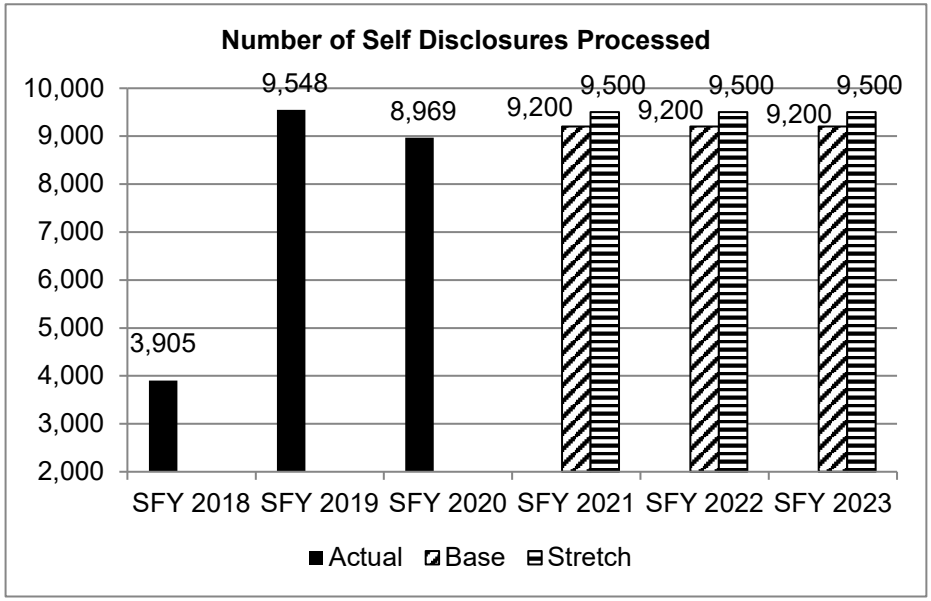
2d. Provide a measure(s) of the program's efficiency.



Return on Investment was calculated by dividing MMAC expenditures by MMAC recoveries. Recoveries include checks received, Medicaid reimbursement offsets, and claims voided on-line through the adjustment process.



Self Disclosures are recoveries for errors that are reported to MMAC by the providers.

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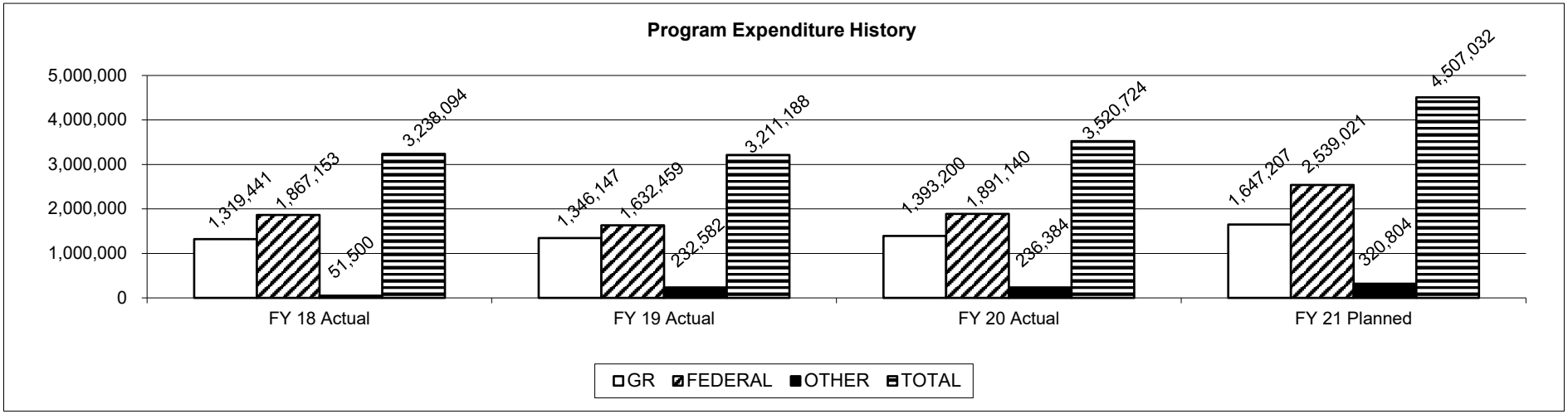
3. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year. (*Note: Amounts do not include fringe benefit costs.)*



Planned FY 2021 expenditures are net of reserves and reverted.

4. What are the sources of the "Other " funds?

Recovery Audit & Compliance Fund (0974)
Medicaid Provider Enrollment Fund (0990)

5. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

Federal law: Social Security Act Section 1902(a)(4), 1903(i)(2), and 1909; Federal regulations: 42 CFR, Part 455; State Regulation: 13 CSR 65-2.020

6. Are there federal matching requirements? If yes, please explain.

MMAC expenditures generally earn a 50% federal match. Expenditures related to the operation of the Medicaid Management Information System (MMIS) earn a 75% federal match. Staff resources employed in the implementation of the new Provider Enrollment - Case Management system earn a 90% federal match.

7. Is this a federally mandated program? If yes, please explain.

Yes. The Social Security Act requires states to report fraud and abuse information and have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.