



**MYERS AND
STAUFFER** LC
CERTIFIED PUBLIC ACCOUNTANTS

IMPORTANCE OF PROGRAM INTEGRITY IN HOME AND COMMUNITY BASED SERVICES

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



■ TOPICS

- Introduction
- Current Medicaid LTSS Environment
- Program Integrity Components
- Long Term Supports and Services (LTSS) Oversight
- Leveraging Policy and Program Integrity

■ MYERS AND STAUFFER LC

- Company organized in 1977
- Works exclusively with state/federal agencies operating public health care programs
- Active engagements in 47 states
- Staff of approximately 700 associates
- Offices in 18 locations



■ SPECIALIZING IN ACCOUNTING, CONSULTING, PROGRAM INTEGRITY AND

YOUR FULL-SPECTRUM PARTNER

AUDIT

**RATE
SETTING**

CONSULTING

**PROGRAM
INTEGRITY**

Extensive Experience with Multiple Provider Categories

- Long-Term Care Facilities
- Hospitals
- Pharmacy
- Home Health Agencies
- Physicians
- Dentists
- Hospice
- FQHC, RHC
- Developmental Disability Providers
- Health Care Delivery System & Payment Transformation
- Fraud and Abuse Detection
- Recovery Audit Contractor
- Managed Care Consulting
- Payment Error Rate Measurement
- WIC Audit
- EHR Audit
- DOJ Fraud Investigations

■ **CURRENT MEDICAID LTSS ENVIRONMENT**

■ LTSS EXPENDITURES

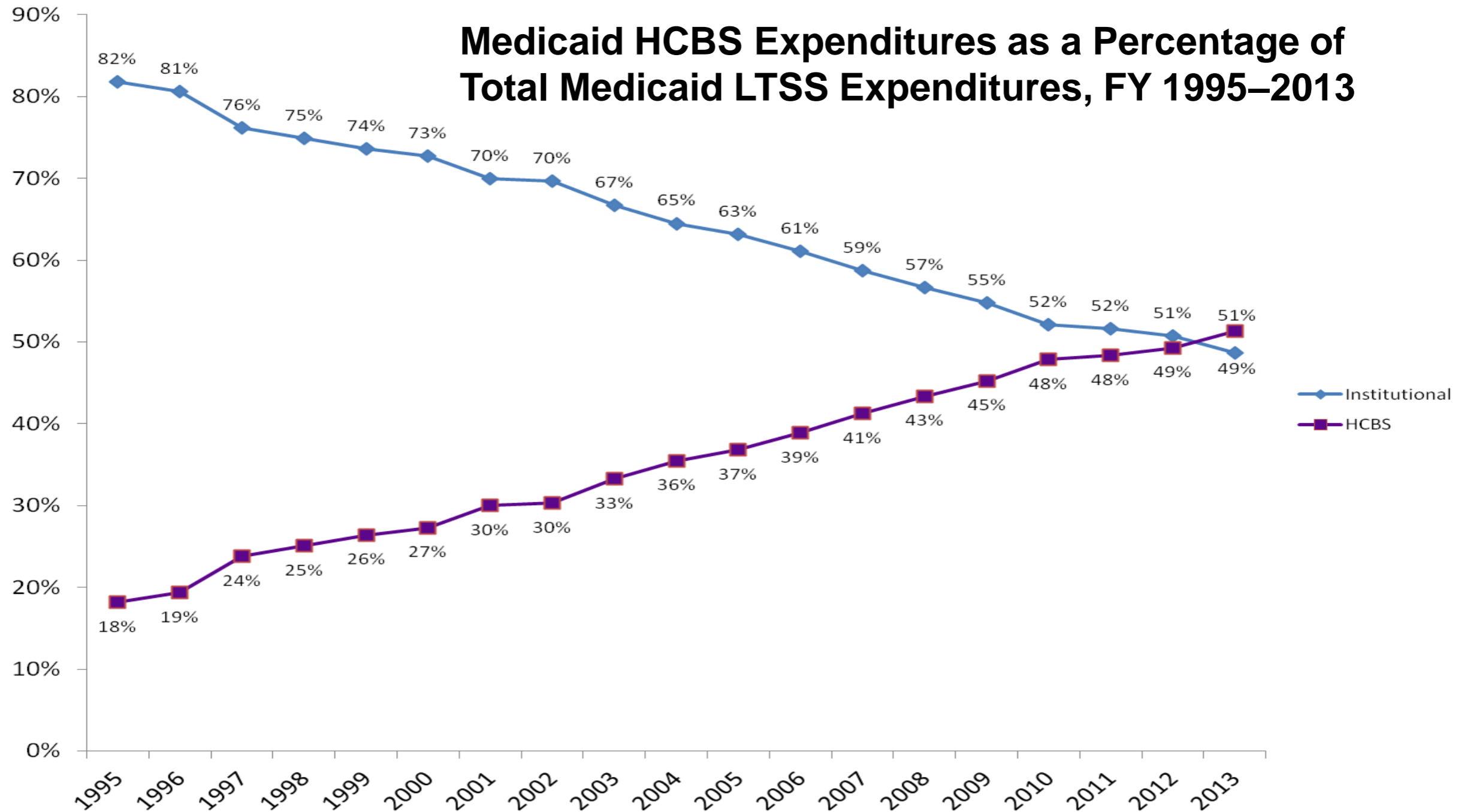
- 2013 National LTSS Expenditures = \$310 Billion*
- 2013 Medicaid LTSS Expenditures = \$146 Billion**
 - \$71 Billion– Institutional Services
 - \$75 Billion – Home and Community Based Services
- 51.3% of total LTSS spending was on HCBS

* Source: KCMU Estimate Based on CMS National Health Expenditure Accounts Data for 2013

**Source: <http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>



Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 1995–2013

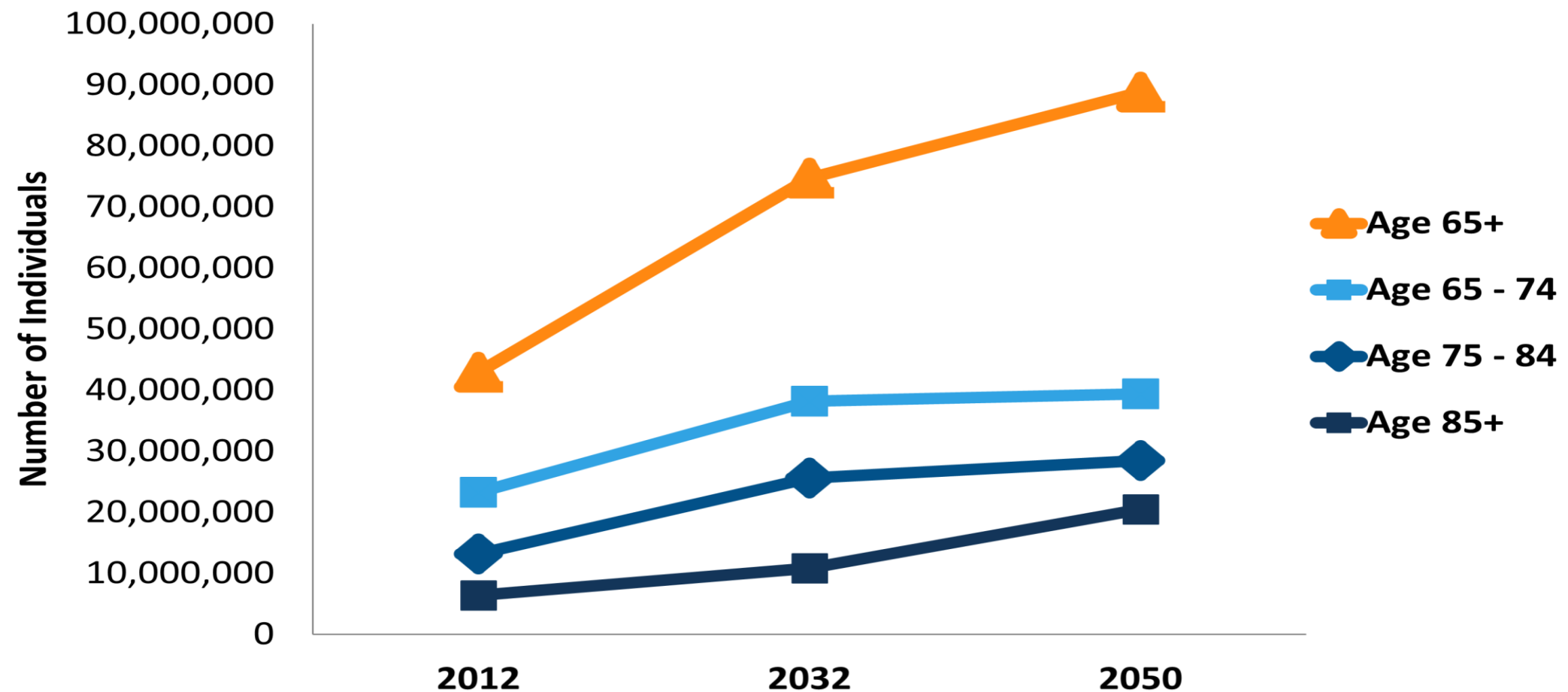


Source: <http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>



■ AGING POPULATION

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050



SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

■ PROGRAM INTEGRITY

■ PROGRAM INTEGRITY

- Proper management of Medicaid to ensure quality and efficient care and appropriate use of funds with minimal waste
- Goes beyond fraud, waste, and abuse. Includes:
 - Provider enrollment
 - Policies and Procedures
 - Services Authorization
 - Compliance
 - Safety and Quality

■ FRAUD, WASTE, AND ABUSE DEFINITIONS

- Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain.
- Waste includes inaccurate payments for services, such as unintentional duplicate payments.
- Abuse represents actions inconsistent with acceptable business or medical practices.

<http://www.gao.gov/assets/130/125646.pdf>

■ FRAUD, WASTE, AND ABUSE

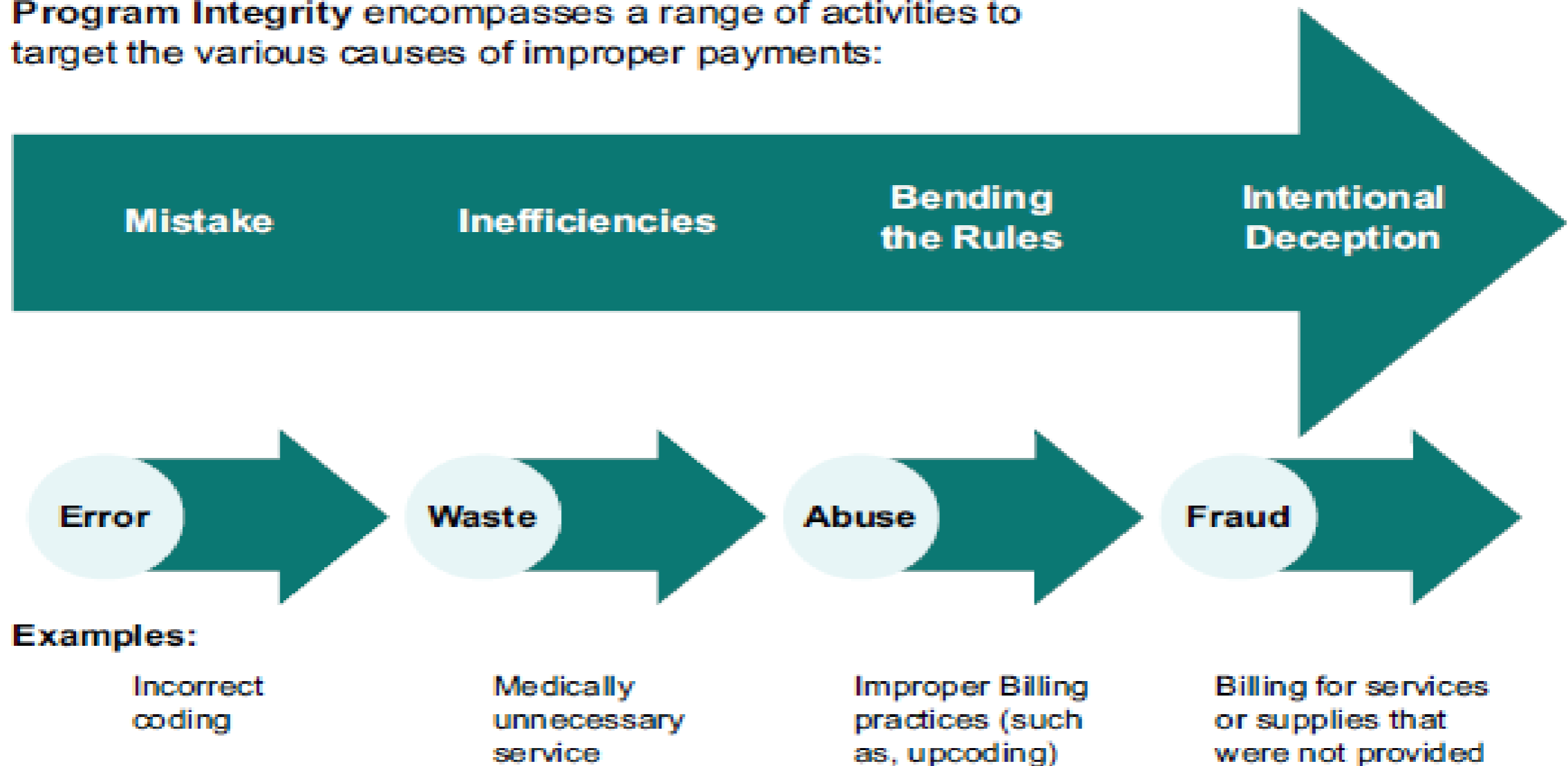
- Federal laws require the states and the Centers for Medicare & Medicaid Services (CMS) ensure the integrity of the Medicaid program
- In fiscal year 2013, CMS estimated that \$14.4 billion (5.8 percent) in Medicaid payments were improper payments.*

*Source: <http://www.gao.gov/assets/670/663306.pdf>



■ TYPES OF IMPROPER PAYMENTS

Program Integrity encompasses a range of activities to target the various causes of improper payments:



Examples:

Incorrect coding

Medically unnecessary service

Improper Billing practices (such as, upcoding)

Billing for services or supplies that were not provided

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf

■ LONG TERM SUPPORTS AND SERVICES OVERSIGHT

■ CASE FOR OVERSIGHT

- Growth in use of HCBS services
- Limited fiscal resources
- Vulnerable citizens
- Delivery of services in isolated environment
- Providers

■ HCBS OVERSIGHT CHALLENGES

- Unique delivery system
- Nontraditional services
- Multiple state agencies involved
- Quality of care

■ OPPORTUNITIES FOR PROGRAM INTEGRITY

- Level of care determinations
- Provider enrollment
- Claims and payment accuracy
- Provider compliance
- Appropriateness of service authorization
- Safety and Quality
- Oversight of managed care organizations or other vendors
- Inform and improve policy and systems

■ LEVERAGING MEDICAID POLICY/ PROGRAM INTEGRITY COLLABORATION



“Maybe sharing an apartment
isn’t a good idea.”

■ **POLICY/PROGRAM INTEGRITY VALUE PROPOSITION**

- Understand data and detect early trends
- Provide policy and contractor contractual compliance feedback
- Identify opportunities
- Heighten fiscal stewardship
- Ensure program compliance with federal and state requirements
- Evolving role with new ACA requirements

THE IMPORTANCE OF PROGRAM INTEGRITY IN HOME AND COMMUNITY BASED SYSTEMS



Date: September 2, 2015

Presented by:

Jennifer Purcell, RN, BSN

Deputy Director, Medical Review

Topics

- ▶ Utilization and Compliance Review
- ▶ Top 10 Policy Violations
- ▶ UCR Program Integrity Referral
- ▶ Surveillance Utilization Review Focus Study

Alliant GMCF: Georgia Medical Care Foundation

- ▶ Alliant GMCF has continuously served the Georgia Medicaid program since 1972
 - Utilization Management
 - Program Integrity
 - Quality Management & Improvement services
- ▶ Staff of approximately 210 employees
- ▶ Current work expanding 8 states

Utilization and Compliance Review Contract

- ▶ The Georgia Department of Community Health (DCH) entered into contract with Administrative Services Organizations, Alliant GMCF/ Georgia Medical Care Foundation to perform UCR services for specific portions of the State's Medicaid program statewide.
- ▶ Alliant GMCF provides on-site and desktop UCR services designed to ensure compliance with the Improper Payments Information Act of 2002 (Public Law No. 107-300).

UCR Background

- ▶ DCH is designated as the “single state agency” for the administration of the Medicaid program under Title XIX of the Social Security Act
- ▶ The Office of Inspector General (OIG) within DCH is responsible for performing investigations and audits to monitor Medicaid policy compliance
- ▶ The Program Integrity section within OIG identifies and responds to fraud and abuse by individuals and providers

Utilization and Compliance Review Contract

- ▶ Provides validation that payments made to health care providers match the services rendered
- ▶ Document compliance with State Medicaid provider policies
- ▶ Assure that the level of care provided to Medicaid patients meet the conditions of participation as outlined in General Conditions, Section 106 or Part 1 – Policy and Procedures Manual

Utilization and Compliance Review Contract

- ▶ Designed to strengthen the ability of the DCH Office of Inspector General's (OIG) efforts to safeguard the integrity of the Medicaid program
- ▶ Improve the ability of DCH OIG to leverage program data to detect and prevent improper payments
- ▶ Strengthen the ability of the DCH to safeguard state and federal Medicaid dollars from diversion into fraud, abuse, and waste
- ▶ Expand the capacity of DCH to protect the integrity of the State Medicaid program

Developing a Methodology for UCR Reviews

- ▶ For each review type, the Department of Community Health Provider Manual was carefully reviewed to establish policy citations, and these were loaded into the MedGuard system
- ▶ MedGuard is the application utilized by Alliant GMCF to capture, track, and analyze review data for the UCR contract.

MedGuard:

“Data Driven Approach”

- ▶ All provider reporting and communications are driven by system data.
- ▶ Policy Citations and Findings are unique at the Category of Service AND program level. This means that we can capture the specific findings associated for a particular service.
- ▶ Policy Citations and Findings are populated via the database. As the review model changes (policy, findings, new/modified programs), we simply update the database—meaning that there are no system changes, and a rapid turnaround time.

MedGuard Advantages

- ▶ Consistency and standardization of reviews and training
- ▶ Increased speed of review and productivity of reviewers
- ▶ Ability to produce “real time” ad hoc reports as needed
- ▶ Management reports for enhanced billing and bidding
- ▶ QA trending reports and increased educational opportunities
- ▶ HIPAA compliance with all of files scanned and stored in specific provider review report
- ▶ Staff have access to desktop 24/7
- ▶ Increased recoupment for policy violations or quality of care concerns
- ▶ Greater success rate at hearings due to policy citation inclusions

Important Aspects of the Work

- ▶ Policy citations are used as educational tools with providers
- ▶ Distinguishing between minor policy violations and more significant ones that may lead to member harm or poor quality care
- ▶ Providers always have an opportunity for a discussion conference with DCH and the opportunity for an Administrative Review of findings.

Summary Statistics for Members Reviewed by Provider Category of Service Annual Report FY 2015

Category of Service	Members Reviewed	Total Reviews	Total Claim Lines Reviewed	Dollars Paid for Claims Reviewed	Initial Dollars Identified	Percent Identified
320-DME	2,166	40	5,107	\$812,753	\$466,086	57%
330-OP	1,093	23	3,860	\$1,344,098	\$837,532	62%
370-ET	947	47	2,905	\$233,396	\$83,564	36%
440-CSB	150	4	2,176	\$249,904	\$195,603	78%
690-HOSPICE	41	20	5,183	\$4,168,448	\$3,199,390	77%
971-GAPP	1	1	35	\$13,580	\$13,580	100%
(5) HCBS Waivers	1,726	100	189,769	\$37,938,665	\$9,889,946	26%
Totals	6,124	235	209,035	\$44,760,844	\$14,685,701	33%

- ▶ Initial Dollars Identified = Dollars identified for potential recoupment before administrative reviews.

Top 10 Policy Violations

HCBS Program #1

Rank	Description	Number of Violations
1	The documentation was not sufficient to indicate the service and frequency were provided according to the care plan or service plan as required by policy.	455
2	Medication supervision was not managed in accordance with current policy or applicable laws and regulations.	301
3	The documentation was not adequate or appropriate or did not include all elements required by policy.	287
4	The need for and the provision of the service was not assessed or monitored as required by policy.	252
5	All required documentation was not filed in the record.	136
6	The provider did not have written procedures to handle emergencies.	133
7	The service billed for this date was not documented.	104
8	The service was not authorized or certified/ordered as required by policy.	104
9	Services were not provided in an appropriate environment for the person supported or served.	97
10	Medication storage was not managed in accordance with current policy or applicable laws and regulations.	88

Top 10 Policy Violation HCBS Program #2

Rank	Description	Number of Violations
1	The need for and the provision of the service was not assessed or monitored as required by policy.	121
2	The documentation was not adequate or appropriate or did not include all elements required by policy.	80
3	The documentation was not sufficient to indicate the service and frequency were provided according to the care plan or service plan as required by policy.	64
4	Medication supervision was not managed in accordance with current policy or applicable laws and regulations.	60
5	Documentation errors were not corrected according to currently accepted standards of medical practice.	42
6	The service was not authorized or certified/ordered as required by policy.	39
7	All required documentation was not filed in the record.	17
8	The provider did not have written procedures to handle emergencies.	5
9	The units of service billed were not supported by the units of service documented.	5
10	The provider of the service was not qualified or licensed to provide the service.	3

Top 10 Policy Violations

HCBS Program #3

Rank	Description	Number of Violations
1	The documentation was not adequate or appropriate or did not include all elements required by policy.	2275
2	The service billed for this date was not documented.	1307
3	Medication supervision was not managed in accordance with current policy or applicable laws and regulations.	1186
4	The units of service billed were not supported by the units of service documented.	984
5	The provider did not comply with all of the Departments requirements applicable to the category of service in which the provider participates under the Conditions of Participation.	744
6	Documentation errors were not corrected according to currently accepted standards of medical practice.	744
7	The service was not authorized or certified/ordered as required by policy.	614
8	The documentation was not sufficient to indicate the service and frequency were provided according to the care plan or service plan as required by policy.	520
9	The need for and the provision of the service was not assessed or monitored as required by policy.	304
10	The procedure code billed was not correct for the service that was provided.	139

UCR Program Integrity Referral: HCBS Programs #1 and #2

- ▶ Reason for Referral
 - Noncompliance with program requirements as identified in process of UCR review

UCR Program Integrity Referral: HCBS Programs #1 and #2 Providers

► Clinical Records Findings

- Supervisory visits completed over the phone, not face to face and not timely
- The initial assessment and care plan development completed by an LPN, not an RN
- Service record forms completed by 2 different aides for the same period of time
- Inappropriate corrections made in record
- Service record forms were found to have been completed prior to services being rendered

UCR Program Integrity Referral: HCBS Programs #1 and #2 Providers

► Billing Findings

- Services provided under the Program 1 were billed according to the maximum number of units authorized rather than by the units actually provided
- For Program 2 billing, the provider incorrectly billed using the incorrect codes and calculated units by 15 minutes instead of 30 minutes

UCR Program Integrity Referral: HCBS Programs #1 and #2 Providers

► Personnel Files Findings

- Staff members hired with no health care experience and no orientation on record
- Criminal background checks and TB tests missing on some employees
- There is no designated professional on staff providing oversight and supervision of aides
- Staff providing care prior to CPR and First Aid certifications becoming effective

UCR Program Integrity Referral: HCBS Programs #1 and #2 Providers

► Action Taken:

- Outline of deficiencies and education provided at exit conferences
- Provider notified UCR review will be repeated in 6 months
- Recouped **\$17,007.97** for HCBS Program #1 and **\$168,375.80** for HCBS Program #2

Surveillance Utilization Review Services (SURS)

- ▶ Responsible for assessing utilization patterns of covered Medicaid services by a fee-for-service member
- ▶ By analyzing and comparing members to their peer groups, mis-utilizations of covered Medicaid services can be identified
- ▶ Alliant GMCF submits written recommendations to Medicaid based on individual member study

Focus Study: HCBS Program #2

- ▶ Study of members who were enrolled in HCBS Program #2 who were 64 and over and had the highest ranked inpatient charges
- ▶ Study goal was to assist DCH in identifying trends of those Medicaid members enrolled in the waiver program including utilization patterns and medical necessity

HCBS Program #2 Focus Study Findings

- ▶ Members with needs beyond an intermediate nursing home level of care (LOC) provided by the waiver as evidenced by the high number of hospitalizations
- ▶ Members receiving long term care (LTC) or hospice services simultaneously, which is against policy.

HCBS Program #2 Focus Study

Findings

- ▶ Medicaid records of 125 members were requested and reviewed for the study
- ▶ 44 members (35%) were identified as *members of concern*
- ▶ 31 members (25%) had 5 or more hospital stays during the one year review period
- ▶ 3 members (2%) had a high number of inpatient days ranging from 95-148 days
- ▶ 16 members (13%) required a higher level of care than that which could be provided through the waiver program
- ▶ 10 members (8%) had waiver and Long Term Care (LTC) benefits at the same time
- ▶ 4 members (3%) had waiver and Hospice benefits at the same time
- ▶ 12 members (10%) were non-compliant with their plan of care and/ or follow-up instructions

HCBS Program #2 Focus Study Recommendations

- ▶ Request reassessment by the Case Management sites with submission of documents to Alliant GMCF's Medical Review Team of those members who have been identified as needing a higher level of care than the waiver provides, and consider recoupment of paid claims on these members
- ▶ Require Case Management sites to submit documentation demonstrating oversight and coordination of services for those members who had repeated hospital encounters, hospitalizations, or issues of non-compliance and consider recoupment of paid claims on these members determined to have no or inadequate oversight

HCBS Program #2 Focus Study Recommendations

- ▶ Request that sites submit documentation as to the rationale for retaining those members in the program who are chronically non-compliant, as they meet the involuntary discharge criteria outlined in Section 1405 of the policy manual, and consider recoupment of paid claims on these members
- ▶ Recommend recoupment of paid claims of those members in LTC or Hospice simultaneously with the waiver

Questions?

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MAKING HEALTH CARE BETTER