HCB Waiver Service Authorization and Provider Billing Documentation

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ALVAREZ & MARSAL

MACS CEO & Leadership Conference | Strategies for Navigating Change

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MACS
Maryland Association of Community Services

A&M

Agenda

Time	Topic
10:00 AM	Background
10:15 AM	US HHS Office of Inspector General Audits
10:45 AM	Federal and State Regulatory Authority
11:15 AM	Our Approach
11:30 AM	The Results
12:00 PM	Next Steps, Questions and References

Background

Developmental Disabilities Administration's efforts and A&M's role

Background of DDA's Efforts

DDA's efforts and A&M's Role

Through the 2018 Community Pathways renewal & implementation of Community Supports and Family Supports Waivers, DDA introduced new services & revisions to existing services - to effectively deliver theses service it is imperative that:

- There are clear guidelines for DDA to authorize services
- Providers understand requirements for documentation

A&M worked with state staff and providers to define documentation expectations to:

- Enhance provider understanding of new and revised services
- Develop reasonable expectations for provider documentation
- Mitigate Risk related to Federal and State audits

US HHS OIG Audits

Why service authorization and provider documentation matter

US HHS OIG Audits

Why service authorization and provider documentation matter

- March 2011: Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health
- January 2015: New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program
- October 2016: State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program

US HHS OIG Approach

Why service authorization and provider documentation matter

- Reviewed the supporting documentation including individual service plans, monthly staff notes, attendance reports, clinical notes, and other medical history notes
- Verified services were paid accurately based on the individual payment rate sheets provided by the State agency
- Ensured claimed services were included in the approved plan
- Confirmed beneficiary eligibility for services
- Determined whether services were provided by appropriately qualified staff

US HHS OIG Audits – New Mexico

US DHHS Office of Inspector General, *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health* (March 2011) at https://oig.hhs.gov/oas/reports/region6/60900062.asp

New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health (March 2011)

- Period: 10/1/2006 – 9/30/2008
- Statewide personal care expenditures $433M ($309M Federal Share)
- Ambercare revenue $33M ($24M Federal Share)
- N = 100
- 77 Compliant / 23 Partially compliant
- Improper Claiming = $9,043
- Estimated Improper claiming for Ambercare = $889K Federal Share

Audit Findings – New Mexico

Why service authorization and provider documentation matter

- Personal Care Assistants must have 12 hours of annual training
- Current CPR certification
- Prior Approval from Legal Guardian
- Physician Authorization

US HHS OIG Audits – New York

US DHHS Office of Inspector General, *New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program* (January 2015) at https://www.oig.hhs.gov/oas/reports/region2/21001044.asp

New York Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program (January 2015)

- Period: Calendar Years 2006 through 2008
- OPWDD Waiver Program Expenditures = $10.5B ($5.4B Federal Share)
- N= 137 Beneficiary Months
- 100 Compliant and 37 noncompliant beneficiary months
- Improper Claiming = $79,328
- Estimated Improper Claiming $77M

Audit Findings – New York

Why service authorization and provider documentation matter

NY OPWDD Regulations

- 1 Unit: Document at least two face-to-face services in 4-6 hours
- ½ Unit: Document at least one face-to-face service in at least 2 hours
- Participant's response to services must be documented

Documentation Findings

- Full unit billed – only 1 face-to-face service documented
- Face-to-face service not documented / no description of service provided
- Participant's response to services not documented
- No documentation of the number of service hours

US HHS OIG Audits – State Agencies

US DHHS Office of Inspector General, *State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program* (October 2016) at https://oig.hhs.gov/oas/reports/region7/71603212.pdf

State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for HCBS (October 2016)

State	Unallowable Room and Board Costs	Other Unallowable and Unsupported Costs	Total
Maryland	$21M	$45M	$66M
New York	$61M	$0	$61M
Missouri	$3M	$41M	$44M
South Carolina	$6M	$0	$6M
TOTAL	$91M	$86M	$177M

Audit Findings – State Agencies

Why service authorization and provider documentation matter

- Individual Service Plan issues
  - No individual service plan
  - Service not authorized or not provided as authorized
- Inadequate documentation of staff qualifications
- Level of need criteria not met for add-on services
- Services billed for people who were not present due to their attendance at other facilities
- Services not adequately documented to demonstrate services were actually provided
- Service Payment Rate issues
  - Unapproved costs were not excluded
  - Payment rates not properly supported and documented

Federal & State Regulatory Authority

Parameters for Service Authorization and Provider Documentation

Regulatory Authority

CMS 1915(c) Home and Community Based Waiver Instructions, Technical Guide and Review Criteria (January 2015) at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf

- Focus on fraud, waste and abuse
- Establish service authorization process
- Establish pre-payment review (i.e. LTSS edits)
- Establish post payment audits
  - Scope / Sampling
  - Frequency
  - Methodology

Regulatory Authority

Ensuring the Integrity of HCBS Payments: Billing Validation Methods (December 2016) at https://www.medicaid.gov/medicaid/hcbs/downloads/training/billing-validation.pdf

Federal Regulations

- State Medicaid Manual, Pub.45
- 42 CFR
- 1915(c) Waiver Application Technical Guide
  - I-2d Billing Validation Process
  - I-2e Billings and Claims Record Maintenance Requirements

State Regulations and Policies

- OIG Audits may “look back” to previous 6 years
- Audits must consider authority applicable to time period

Regulatory Authority

Parameters for service authorization

42 CFR 441.301(c)(2)(xii) states:

"…Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must…**Prevent the provision of unnecessary or inappropriate services and supports**."

Regulatory Authority

Parameters for provider documentation

State Medicaid Manual, Publication 45, §2500.2

Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Your supporting documentation includes at a minimum the following:

- Date of service;
- Name of recipient;
- Medicaid identification number,
- Name of provider agency and person providing the service;
- Nature, extent, or units of service; and
- Place of service.

§2497.2 Availability of Documentation

Requires accounting records be supported by appropriate source documentation….and…readily available for audit.

Our Approach

Collaborate to provide clarification

Our Approach

Collaboration to provide clarification

Service Authorization

- Facilitated by A&M
- DDA Subject Matter Experts
  - DDA Leadership
  - DDA Programs Staff
  - Regional Office Personnel
  - Clinical Staff

Provider Documentation

- Facilitated by A&M
- DDA Leadership
- DDA Subject Matter Experts
- DDA Provider Representatives
- MACS Leadership

Our Approach - Provider Input

Collaboration to provide clarification

Organization	Participant
ARC of Baltimore	Kathleen Durkin
ARC of Northern Chesapeake	Shawn Kros
ARC of Southern MD	Terry Long
Chesterwye Center	Debra Langseth
Community Support Services	Susan Ingram
Compass MD	Rick Callahan
Dove Pointe	Chris Parks
Flying Colors of Success	Mike Hardesty
MACS	Lauren Kallins
MACS	Laura Howell
Providence Center	Joan Miller
Spring Dell Center	Donna Retzlaff

Documentation Requirements & Standards

Collaboration to provide clarification

Claim Documentation Requirements

- Date of Service
- Participant's name
- Medicaid ID
- Name of Provider
- Name of Person Providing Service
- **Nature, extent or units of service**
- Location
- Provider qualifications

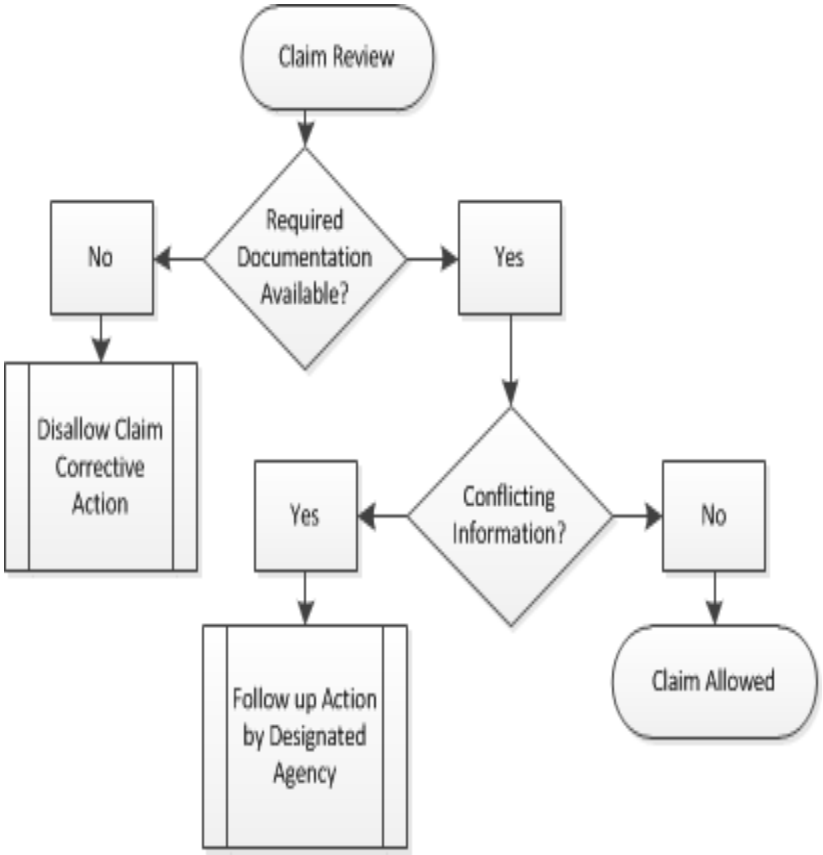
Documentation Standards

- Service monitoring notes
- Service communication & coordination
- Quality reviews

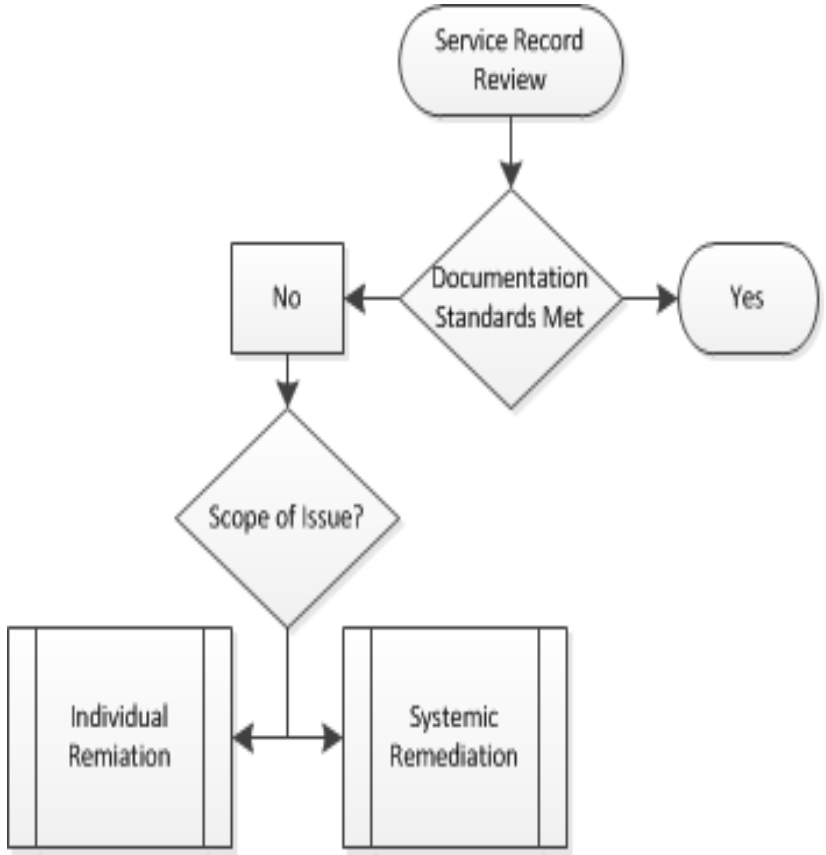
Claim Audit vs. Quality Review

Collaboration to provide clarification

Claim Audit



Quality Review



Clarifying Service Monitoring Notes

Service Monitoring Note

(aka "Progress Note")

- Service monitoring by CCS
- Ensures the provision of services as authorized in the plan
- Review documentation, observe service delivery, talk to the participant/guardian, etc.
- Assesses and documents the presence (or not) of progress
- Very specific requirements regarding what must be documented
- Happens well after service provision bill submission - inappropriate requirement for submission of billing/FFP claiming

Service Note*

- Used to record information related to service delivery
- Typically done at the end of service delivery…staff may do this before they leave a shift or a person's home
- May include an assessment of progress – but is not required
- Used to note important information, communicate with team & service providers
- Used as one of multiple sources of information used in the assessment of "progress"

*Clarification of LTSS Field for "Progress Note"

Our Approach

Collaboration to provide clarification

Presumption of requirements for FFP claiming (LTSS)

- Eligible Participant
- Qualified Provider

Presumption of requirements in **§2500.2** (LTSS)

- *Date of service*
- *Name of recipient*
- *Medicaid identification number*
- *Agency / person providing the service*
- *Place of service*

FOCUS

- Service Authorization Requirements
- Provider Billing Documentation - **nature, extent, or units of service**

The Results

Service specific service authorization and provider documentation requirements

Results – Authorization (General)

Service specific service authorization requirements

- Clarification of service requirements and limits
- Consistent language and expectations regarding the need to exhaust all “appropriate & available services”
- Specification of documentation that must be submitted with a request for service authorization

Results – Documentation (General)

Service specific provider documentation requirements

- Specification of requirements for day services, ensuring billing documentation includes start/end times that occur within a day, clarifying that billing cannot occur for time the participant is absent, for example, to go to a doctor's appointment

- Clarification for residential and day services that billing documentation must include affirmation the service was provided rather than an assumption the participant is present unless there is information documenting his/her absence

Authorization & Documentation

Requirements for enhanced staffing ratios example: Community Living Group Home

Service Authorization

- Documentation requirements
- Service Criteria Clarification
- Examples of what may be authorized
- Specific requirements re: behavioral needs & medical needs
- Time limits

Provider Documentation

- Staff time sheets or payroll records with start/end time of staff providing dedicated hours
- For each block of consecutive units of service, document service performed

Dedicated Behavioral Hours

- May use the BP tracking form

Results – Residential Services

Service specific service authorization and provider documentation requirements

Service Authorization

- Specifies criteria for the authorization of residential supports
- Specifies criteria for dedicated hours

Provider Billing Documentation

- Attendance log that documents hours to justify a day rate
- Documented affirmation service was provided
- Adds specific requirements, i.e. requirements for shared living, retainer fee, etc.

Results - Meaningful Day

Service specific service authorization and provider documentation requirements

Service Authorization

- Must be 18 or no longer in school
- Reflects needs/preferences specified in the PCP
- Specifies service limits
- Specifies required documentation of need
- Specifies other criteria, i.e. fading plan for ongoing job supports when appropriate

Provider Billing Documentation

- Milestone: Requirements are described/specified
- FFS: Staff timesheets with start/end times, dates of service and service note describing tasks relative to the PCP
- Other (monthly): Requirements are specified, i.e. monthly service monitoring note
- Specifies requirements for documenting staffing ratios for group activities

Results – Support Services

Service specific service authorization and provider documentation requirements

Service Authorization

- Exhaust other services
- Reflects needs/preferences specified in the PCP
- Specifies service limits
- Specifies required documentation of need
- Specifies other criteria, i.e. assistive technology cannot be experimental
- Clearly distinguishes between State Plan personal care and personal supports

Provider Billing Documentation

- Specifies requirements for all providers and specific requirements for OHCDS
- Specifies milestone requirements, i.e. Behavioral Assessment
- Specifies requirements for new services, i.e. live in caregiver supports, etc.
- Provides clarity around new nursing services
- Respite Care – specifies requirements by setting

Next Steps

Service specific service authorization and provider documentation requirements

- Office of Health Services and Attorney General Review
- Revisions per OHS and AG review
- Information dissemination and training
- Questions?

References

US HHS OIG Audit Reports

- US DHHS Office of Inspector General, *New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program* (January 2015) at https://www.oig.hhs.gov/oas/reports/region2/21001044.asp
- US DHHS Office of Inspector General, *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health* (March 2011) at https://oig.hhs.gov/oas/reports/region6/60900062.asp
- US DHHS Office of Inspector General, *State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program* (October 2016) at https://oig.hhs.gov/oas/reports/region7/71603212.pdf

References

CMS Manuals, Technical Guides

- CMS 1915(c) Home and Community Based Waiver Instructions, Technical Guide and Review Criteria (January 2015) at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf
- Preventing Medicaid Improper Payments for Personal Care Services booklet at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf
- Preventing Unallowable Costs in HCBS Payment Rates (June 2018) at States may use the Medicare Provider Reimbursement Manual Chapter 21 as a resource for determining costs ineligible for federal reimbursement at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

References

CMS Technical Assistance

- Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services (February 2016) at https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-3a-fwa-in-pcs-training.pdf
- Increasing Fiscal Protections for Personal Care Services (April 2016) at https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-increasing-fiscal-protections-v6.pdf
- Preventing Medicaid Improper Payments for Personal Care Services at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf
- Preserving Self Direction Rights (June 2016) at https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-preserving-self-direction-rights.pdf
- Ensuring the Integrity of HCBS Payments: Billing Validation Methods (December 2016) at https://www.medicaid.gov/medicaid/hcbs/downloads/training/billing-validation.pdf