COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 11, 2012

MEMORANDUM

TO: The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Lacey E. Putney, Chair
House Appropriations Committee

The Honorable Charles J. Colgan, Chair
Senate Finance Committee

FROM: Cynthia B. Jones Cynthia B. Jones

SUBJECT: Report on the Evaluation of Effectiveness and Appropriateness of Review Methodology for Home and Community Based Services

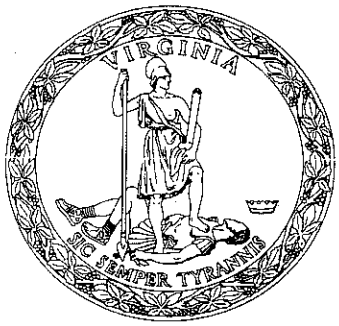
Item 297 AAAAA of the 2011 Appropriations Act directed DMAS to consult with representatives of providers of Home and Community Based Services (HCBS) concerning audits of such providers, evaluate the effectiveness and appropriateness of the audit methodology and report to the Governor and Chairman of the House Appropriations Committee and Senate finance Committee by November 1, 2011. As directed by the Act, DMAS held a series of stakeholder meetings in order to obtain input from HCBS providers on the DMAS audit methodology. In addition, DMAS conducted a survey of other state Medicaid programs, in order to determine common audit practices, and DMAS considered and addressed issues raised in previous versions of Appropriations Act language. This report: 1) describes the stakeholder process; 2) describes DMAS audit programs; 3) describes HCBS services; 4) provides a summary of DMAS audit activities and recent audit results; 5) reports on the survey of state Medicaid audit practices with comparisons to DMAS practices; and 6) discusses stakeholder issues and provides recommendations.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

Enclosure

Cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources

EVALUATION OF EFFECTIVENESS AND APPROPRIATENESS OF REVIEW METHODOLOGY FOR HOME AND COMMUNITY BASED SERVICES



DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

November 1, 2011

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Background

Legislative Mandate

Item 297 AAAAA of the 2011 Appropriations Act directed DMAS to consult with representatives of providers of Home and Community Based Services (HCBS) concerning audits of such providers, evaluate the effectiveness and appropriateness of the audit methodology and report to the Governor and Chairman of the House Appropriations Committee and Senate finance Committee by November 1, 2011 (Attachment I). As directed by the Act, DMAS held a series of stakeholder meetings in order to obtain input from HCBS providers on the DMAS audit methodology. In addition, DMAS conducted a survey of other state Medicaid programs, in order to determine common audit practices, and DMAS considered and addressed issues raised in previous versions of Appropriations Act language. This report: 1) describes the stakeholder process; 2) describes DMAS audit programs; 3) describes HCBS services; 4) provides a summary of DMAS audit activities and recent audit results; 5) reports on the survey of state Medicaid audit practices with comparisons to DMAS practices; and 6) discusses stakeholder issues and provides recommendations.

Stakeholder Process

DMAS solicited written comments from stakeholders and scheduled a series of meetings with representatives of HCBS providers and other interested stakeholders, in order to receive input on the DMAS audit process. Written comments were received, and meetings were held on August 24, 2011, September 12, 2011, September 21, 2011 and September 26, 2011 at the DMAS offices in Richmond, Virginia. A list of meeting participants is found in Attachment II. Three of the four meetings included a large group of stakeholders and were facilitated by a past director of the DMAS Internal Audit Division, who has more than 30 years of auditing experience. One meeting was held between DMAS staff and a representative from the Virginia Association for Home Care and Hospice (VAHCH).

During the meeting of August 24, 2011, DMAS staff provided an overview of the audit process, reviewed the State survey results and facilitated a working session for stakeholders to provide input on audit practices that are and are not working and desired changes. Topics for the next meeting were identified and included: 1) partial versus total retraction; 2) definition of substantial compliance; 3) assurances that policies fit regulations; 4) use of technology; 5) consistent application of regulations; and, 6) expectation of auditors. The minutes from the meeting may be found in Attachment III.

The second meeting was held September 12, 2011. The meeting was facilitated and solicited comments from stakeholders on three salient themes: 1) sampling methodology; 2) the definition and use of a standard of substantial compliance; and 3) partial retraction. The meeting held on September 21, 2011 included a representative from the VAHCH and DMAS staff. During this meeting, the introduced (versus final)

Appropriations Act language and provider community concerns were reiterated and discussed. The last meeting held September 26, 2011 was used to recapitulate and discuss audit methodology and process issues.

In summary, stakeholders desired: 1) changes to the methodology used to select providers for audit; 2) random versus targeted samples (of both providers and claims); 3) samples of claims that are limited to five percent of a provider's claims; 4) samples that cover a maximum of six months; and 5) a standard of substantial versus one hundred percent compliance that is tied to retractions. In addition, desired audit process changes were discussed. Details of stakeholder concerns and DMAS' responses are discussed later in this report.

Overview of DMAS Reviews and Audits

Background

The Medicaid program is a partnership between Federal and State governments; Federal regulation provides a framework for Medicaid integrity activities, but each State is given wide latitude in developing their individual programs. DMAS programs have evolved over time, based on the judgment of State officials and DMAS executive staff, to fit the needs of the Virginia Medicaid program. Federal auditors, on average, review DMAS annually to ensure that the Medicaid program is in compliance with Federal regulations, and they conduct quarterly reviews of Medicaid expenditures via the CMS-64 reporting process. To date, Federal auditors have ascertained that DMAS is in compliance with Federal regulations. DMAS conducts several types of Medicaid integrity activities, including Quality Management Reviews (QMR), utilization reviews, financial review and verification, and investigations of fraud and abuse, each corresponding to sections of the Code of Federal Regulations. Utilization reviews and financial review and verification encompass the audit process which is the major subject of this report.

Quality Management Reviews (QMRs)

Regulations at 42 CFR §441 Subpart G address the Federal framework for HCBS waiver requirements, and the DMAS QMRs correspond to these regulations. The DMAS Long Term Care Division conducts the QMRs. The primary focus of QMRs is to assure the health, safety and welfare of individuals receiving HCBS. QMRs are federally mandated by 42 CFR § 441.302 and require that: 1) DMAS assure that necessary safeguards have been taken to protect the health and welfare of the recipients of services; 2) assure that all provider are in compliance with applicable State and federal standards; and, 3) assure financial accountability for funds expended for HCBS. If DMAS cannot demonstrate compliance with Federal requirements, there is a risk that the waivers may not be renewed by the Centers for Medicare and Medicaid Services (CMS).

Among providers selected for review are new providers and providers that have high risk indicators, based on a review of claims and other reports. DMAS conducts both onsite and desk reviews that include critical policies and healthcare practices pertaining

to the individual, personnel and the agency; screening and prior authorization documentation; billing, including patient pay amounts that may be required; continuity of care; staff qualifications, and the quality of delivered services. Reviews are unannounced. Possible outcomes from QMR include technical assistance, a Corrective Action Plan submitted to DMAS, referral to the Provider Review Unit and/or referral to the Medicaid Fraud Control Unit. Retractions are not tied to QMR results.

Utilization Review and Financial Review and Verification (Audits)

42 CFR §456 deals with utilization control and states that "the Medicaid agency must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of services and against excess payments". Further, §456.23 states that,

> *"The agency must have a post-payment review process that allows State personnel to develop and review...provider service profiles; and exceptions criteria; and identifies exceptions so that the agency can correct misutilization practices of recipients and providers".*

Audits are conducted by internal DMAS Program Integrity staff and their contractor, Clifton Gunderson (CG). Audits are conducted to: 1) assure that Medicaid payments are made for covered services that were actually provided and properly billed and documented; 2) calculate and initiate recovery of overpayment; 3) educate providers on appropriate billing procedures; 4) identify potentially fraudulent or abusive billing practices and refer fraudulent and abusive cases to other agencies; and 5) recommend policy changes to prevent waste, fraud and abuse. Audits rely on documentation to determine whether the services delivered were appropriate, continue to be needed and are in the amount and kind required. Chapter VI of the Elderly and Disabled with Consumer Direction (EDCD) Provider Manual describes the process in which a team audits patient records, paying specific attention to the Plan of care, supervisory notes, daily records, progress notes, screening packages and any other documentation necessary to determine if appropriate payment was made for services. In addition, the Manual states:

> *"Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services."* And,
>
> *"Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and retraction of payment may be necessary."*

The first step of the CG audit process involves running claims through a proprietary data mining software program that is customized for use with DMAS data. CG uses claims data spanning a fifteen-month period in order to identify provider records for review. The use of a fifteen-month period allows reviewers to review records of individuals who are expected to have had required annual re-assessments and updates of

their Plan of Care and to observe trends in the data. Examples of trends of interest include unusual increases or decreases in claims volume, gaps in the data, and high level of hospital readmissions. Sampling is conducted based on accepted accounting standards for non-random samples. According to a CG representative, random sampling is generally used when the goal is to extrapolate the findings to the universe of data from which the sample is drawn. As the results of the reviews are not used for extrapolation, (e.g., to develop an error rate to apply to the universe of claims, including ones that were not in the sample) a non-random sampling method is appropriate. The size of the sample varies, but is often twenty-five to thirty-five percent of the total number of claims for an individual provider, but may be higher if previous reviews of the provider resulted in a significant finding.

Once the providers and samples are identified, they are reviewed by DMAS Provider Review Unit (PRU) staff for approval. In addition, staff in the Long Term Care Division review the selection and eliminate any providers who are involved in a QMR, in order to reduce the burden on the provider. After the final approved selection is made, CG staff contact the providers to schedule a site visit to review and scan individual records. The documentation obtained is reviewed for compliance with specific regulations and manual citations for the services billed. A team of at least two reviewers perform site visits, and all review findings are subject to second-level review with some findings subject to a third, high-level management review. Preliminary findings are submitted to providers who then have an opportunity to submit additional documentation to support their claims. An exit conference is conducted to explain the review findings and appeals process. Providers are also notified and given opportunities for informal and formal hearings to dispute adverse findings. If during an audit evidence of fraud and/or abuse is found, a referral is made to the Medicaid Fraud Control Unit for follow-up and possible investigation.

In addition to reviews performed by CG, the DMAS Provider Review Unit (PRU) conducts audits. The PRU Unit utilizes an annual audit plan to determine selection of provider types to review. The plan is prepared by CG and based on provider type risk assessments. The PRU Unit utilizes J-SURS data mining software program to determine which providers within the provider type are exceeding the billing norms for their peer groups. The J-SURS system profiles provider billing practices and compares them to other providers to reveal outliers and unusual billing patterns. The system ranks providers who exceed defined limits to identify high utilization within their peer group. Once a provider is selected, their claims history is put through a variety of analytical procedures to identify potentially abusive or inappropriate billing patterns, such as billing the same number of units every month, regardless of days per month or holidays; billing high numbers of units; billing for procedures unrelated to diagnoses; billing multiple office visits on the same date; and, a habitual use of high-intensity procedure codes.

Once a provider is selected for a review, they are notified via a medical records request. Records are reviewed, preliminary reports of review findings are mailed to the provider, and the provider has thirty days to provide additional information or an explanation of documentation. An exit conference is held telephonically with the

provider, and the preliminary report is revised if applicable. The final report is then written and sent to the provider. Providers may appeal the final report within specific time frames, based on the type of appeal. According to the Code of Virginia §32.1-325.1(B), "once a final determination of overpayment has been made, the (Medicaid) Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial or the final determination of overpayment". The calculation of overpayments varies, depending on the metric used to determine payment. For claims that are billed based on units of service (such as minutes, hours, weeks, etc.), if documentation supports a lower number of units than those billed, the overpayment is limited to payments associated with the unsupported units only.

Fraud and Abuse

If reviewers find credible evidence of fraud or abuse during an audit, the case is referred to the Office of Attorney General's Medicaid Fraud Control Unit for investigation. 42 CFR §455 Subpart A deals with Medicaid agency fraud detection and investigations programs and states at §455.1(a)(2) "the State (must) have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients". 42 CFR § 455.2 states the definition of fraud as:

> *"An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."*

And abuse is defined as:

> *"Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program."*

Home and Community Based Services

Home and Community Based Services are provided to individuals enrolled in Medicaid who meet criteria for admission to a nursing facility (NF) or Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR) but choose to receive services in a community setting via 1915(c) waiver authority granted by the CMS. DMAS operates seven Home and Community Based Waivers including the Technology Assisted, AIDS, Developmentally Disabled (DD), Elderly and Disabled with Consumer Direction (EDCD), Intellectual Disabilities (ID), Day Support, Assisted Living and Alzheimer's waivers. Waiver eligibility is established by screening teams that use a standardized assessment to determine if individuals meet DMAS' standard criteria and meet the alternative institutional level of care criteria, (NF or ICF/MR).

A variety of services are provided to waiver enrollees, depending upon the waiver in which they are enrolled. Services may include personal care, respite care, adult day health care, and a range of other support services specific to meeting the needs of seniors and individuals with physical, developmental, and/or intellectual disabilities. Once enrolled in a waiver, a R.N., services facilitator or case manager assesses each individual regarding their health and safety status, risks, and support needs and creates a Plan of Care that enumerates the service types and number of hours of care required.

Personal care, respite care, and companion care may be provided through an agency or through self-direction (known as consumer directed). Individuals may select one or both models of service delivery. Under the agency-based model, direct care providers are employed by an agency, and the agency is responsible for billing DMAS for reimbursement. Under the consumer-directed (CD) model, the Medicaid individual or their representative is the employer or the employer of record, respectively, for their attendants and hires, supervises, and trains their attendants. DMAS contracts with a Fiscal Employer Agent (FEA) that provides payroll services for the consumer-directed personal care attendants. The agency and the FEA are responsible for obtaining documentation of the background checks, and training required by DMAS.

Requirements for Medicaid Reimbursement – Utilization Review and Financial Review and Verification (audits)

The DMAS EDCD Provider Manual Chapter VI sets forth DMAS policy for the review of personal and respite care and references 42 CFR §455 and 456 as the authority under which DMAS conducts reviews. The manual states that providers will be required to refund payments made by Medicaid if they fail to maintain any record or adequate documentation to support their claims, or bill for medically unnecessary services.

The EDCD Manual Chapter VI outlines the requirements and methods for utilization reviews. The manual states that, "Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS". Chapter VI lists the required documentation for individual records for agency-directed personal/respite care and enumerates non-reimbursable items, including:

- Screening team authorization not obtained prior to initiation of services and not available at DMAS' request;
- Request for service authorization not submitted by the providers for those services requiring prior authorization;
- The individual receiving waiver services has a patient pay obligation, but such obligation is not indicated on the invoice paid by DMAS;
- Duplicate hours or units billed;
- Services were initiated prior to physician signature on the DMAS-96 screening authorization form or completion of the required screening;

- Provider staff not meeting the minimum staff qualification requirements and therefore not qualified to provide services;
- No initial provider assessment on or before initiation of services, assessments late without documentation;
- Services provided outside of guidelines established in the Plan of Care, or the service not approved on the Plan of Care;
- Inappropriate use of authorized hours, not following the Plan of Care, or providing services not allowed or covered;
- Documentation does not support services billed;
- No evidence of a required criminal history check;
- Amount billed exceeded the amount of services authorized or verified;
- Over billing;
- Required forms not completed or signed and in the file within the allotted time frames;
- Staff providing services outside the scope of practice (e.g. a personal care attendant rendering skilled nursing services which they are not allowed to perform without RN supervision and delegation);
- A higher level of service being provided beyond the individual's documented needs (e.g. an LPN providing skilled respite care when the individual does not have a skilled need);
- Record does not contain physician's orders for skilled services and/or updated order as required, when the service requires a physician order;

DMAS Review Methods and Findings

On October 15, 2010, CG submitted to DMAS the Program Integrity 2007-05 Annual Report conducted from July 1, 2009 through June 30, 2010. The review included thirty-one personal care providers and a sample of 16,626 claims with a combined value of $7,158,921. Within the sample, 6,890 (41% of sampled claims) claims were identified for overpayment with a value of $2,081,264 (29% of total combined claims value)[1]; a summary of relevant findings follows:

For personal care service the most frequent errors include:

1. Aide Record did not contain required weekly or appropriate comments,
2. Dates and/or hours billed did not match the documentation,
3. One or more required preadmission document undocumented,
4. Nurse supervisor did not have documentation of required training and/or prior experience per DMAS standards,
5. Required caregiver/individual and/or aide dated signature is missing or inappropriately dated,
6. Aide did not have documentation of required training,
7. Criminal record clearance not timely,

[1] A claim may have multiple errors.

8. Caregiver/individual and/or aide signature inconsistent on the Aide of Record for the date billed,
9. No documentation of required RN supervisory visit.

For respite care services a sample of 6,044 claims were reviewed with a combined value of $1,449,505, of which 2,896 (48% percent of sampled claims) were identified for overpayment with total overpayments of $595,202 (41% percent of combined payments); the most frequent errors include;

1. Aide Record did not contain required weekly or appropriate comments,
2. Dates and/or hours billed did not match the documentation,
3. One or more preadmission document undocumented,
4. Aide did not have documentation of required training,
5. Caregiver/individual and/or aide signature inconsistent on the Aide of Record for the date billed,
6. The Plan of Care form insufficiently documented or undocumented,
7. No documentation of required RN supervisory visit,
8. Nurse supervisor did not have documentation of required training and/or prior experience per DMAS standards, and
9. Services were provided by member of family without written, objective documentation as to why other providers not available.

Although Home Health is not a waiver service, CG also reviews Home Health providers and Home Health providers have expressed their concern regarding the review process for these services. During state fiscal year 2010, CG reviewed ten Home Health providers reviewing a sample of 714 claims and a combined value of $286,264. Among this sample, 116 claims (16% of the sample) were identified for overpayments valued at $25,063 (8.9% of total sample claims value). The most frequent errors included:

1. The medical record did not contain the documentation to support services for the date/dates of service billed,
2. The medical record did not contain the required timely signature and/or date,
3. The medical record did not contain the required Plan of Care and/or service was provided beyond the certification period for the Plan of Care,
4. The medical record did not contain documentation of the required supervisory visit every two weeks and/or 60 days,
5. Services were provided by an individual for whom the home health agency did not provide evidence of appropriate qualification,
6. The medical record did not contain the required physician's orders and/or the service provided was not ordered by the physician for the date/dates billed,
7. The medical record did not contain documentation of the required physician therapy supervisory visit every 30 days.

Medicaid Review Practices in Other States

As part of this evaluation, DMAS staff surveyed all state Medicaid agencies (including the District of Columbia and Puerto Rico) during July 2011 to learn about their audit practices for HCBS providers. Survey items were constructed based on conversations with DMAS Program Integrity and Long Term Care Division staff, representatives from Clifton Gunderson and on areas of concern expressed by stakeholders in written correspondence to DMAS. The survey focused on determining the criteria agencies use for selecting HCBS providers for reviews, the software and methods employed to select service claims and conduct reviews, review documentation requirements, and provider appeals and recovery process.

The survey was sent via email to individuals identified in the State Program Integrity Contact Directory published by the National Association of Medicaid Program Integrity, a national organization that assists states in providing control of fraud and abuse in the national Medicaid program. Twenty-seven Medicaid agencies responded to the survey (representing a fifty-three percent response rate). The HCBS reviewing practices employed by these agencies are summarized in Table 1 and compared against DMAS' reviewing practices (See IV for the full survey).

Of the twenty-seven agencies responding to the survey, twenty-five conduct audits on different types of HCBS providers (e.g., agency- or consumer-directed personal care providers) while twenty-six do not exclude any providers types from the review process. Twelve agencies use either fraud and abuse detection systems (FADS) or surveillance utilization and reporting systems (SURS) as their data mining software, and thirteen examine up to twenty-four months of claims when reviewing providers.[2] Twenty agencies select providers for review based on high utilization patterns or referrals. Fourteen randomly select provider's claims for review. Twenty agencies use either software (e.g., RAT STAT) or an established sampling method (e.g., sample determined by statistical consultants or based on internal protocols) to determine the number of claims to sample during reviews.[3] Twenty-six agencies consider claims to be non-compliant if required signatures and/or dates are missing from the documentation. Eighteen agencies include non-compliant claims in the recovery process even if corrective action plans are included in the relevant records. Finally, twenty-one agencies require provider claims to meet all documentation requirements during reviews; thirteen allow providers to request a review of all claims (versus a sample) during appeals to demonstrate either compliance or substantial compliance; eighteen do not tie monetary recoveries from providers to the results of QMRs (versus compliance reviews); and

[2]FADS and SURS are claims-based, data mining software applications designed to identify potentially fraudulent activities committed by both health care providers and individuals. These systems can be used to analyze fee-for-service and managed care encounter data from both private and government programs.
[3] RAT STAT is a statistical software package developed by the U.S. Department of Health and Human Services for selecting random samples of claims and estimating improper payments during provider reviews.

nineteen require two to three levels of supervisory review before issuing reports on provider review findings.

As shown in Table 1, survey results reveal that DMAS' review practices are very comparable to the practices employed by most responding Medicaid agencies. For example, DMAS conducts reviews based on different types of HCBS providers and does not exclude any provider types from the reviewing process (although DMAS focuses some reviews on providers that are considered to be higher risk). DMAS also uses SURS as its data mining software; reviews up to fifteen months of claims during reviews; selects providers for review based on high utilization patterns and referrals; considers claims to be non-compliant if required signatures and/or dates are missing from the documentation; requires claims to meet all documentation requirements; does not tie monetary recoveries to QMRs; and requires two levels of supervisory review before issuing reports on provider review findings. While most of DMAS' reviewing practices are similar to the practices used by other agencies, the review did reveal that DMAS practices differ from the majority in two areas: 1) it does not randomly select claims for review, 2) it bases sample size on previous claims history and the type of provider reviewed.

Table 1
Summary of State Medicaid HCBS Reviewing Practices

Response	Frequency (Percentage)	Virginia
Are reviews conducted based on different types of HCBS providers? (N = 27)		
Yes	25 (93%)	✓
No	2 (7%)	
Are certain types of HCBS providers excluded from reviews? (N = 27)		
Yes	1 (4%)	
No	26 (96%)	✓
What data mining software does your state use in the review process? (N = 26)*		
SURS/FADS	12 (46%)	✓ (SURS, SAS)
Business Objects	7 (27%)	
Other (referrals, sampling)	7 (27%)	
How many months of service claims data are examined during provider reviews? (N = 23)		
1 – 12 months	6 (26%)	
13 – 24 months	7 (30%)	✓15 months)
25 – 36 months	4 (17%)	
37 – 72 months	5 (22%)	
What criteria are used to select the specific providers to be reviewed? (N = 27)*		
Utilization	16 (59%)	✓
Referrals	4 (15%)	✓
Other (algorithms, claim reviews)	7 (26%)	
Are service claims randomly selected for review during reviews? (N = 21)		
Yes	14 (67%)	
No	7 (33%)	✓

How does your state determine sample size when selecting claims for reviews? (N = 26)*		
Software	6 (23%)	
Sampling Method	14 (54%)	
Other (review findings, # of claims)	6 (23%)	✓ (claims history, provider type)
Is a claim considered non-compliant if a required signature/date is missing? (N = 26)		
Yes	26 (100%)	✓
No	0	
Response	**Frequency (Percentage)**	**Virginia**
Are non-compliant claims with corrective action plans included in the recovery process? (N = 27)		
Yes	18 (67%)	✓
No	9 (33%)	
Are all claims from providers required to meet all documentation requirements, or are provisions for substantial compliance allowed? (N = 27)		
All claims must meet all documentation requirements	21 (78%)	✓
Substantial number of claims must meet all documentation requirements	1 (4%)	
All claims must meet substantial level of documentation requirements	5 (19%)	
Can providers request a review of all claims during an appeals process (versus a sample) to demonstrate substantial compliance or compliance? (N = 26)		
Yes	13 (50%)	✓
No	13 (50%)	
Are monetary recoveries from providers tied to Quality Management Reviews (versus or in addition to reviews)? (N = 24)		
Yes	6 (25%)	
No	18 (75%)	✓
How many levels of supervisory review of the findings are performed before the provider's reports are issued? (N = 25)		
1 Level	5 (20%)	
2 Levels	9 (36%)	✓
3 Levels	10 (40%)	
4 Levels	1 (4%)	

Note: Survey questions are shaded in gray. Percentages may not sum to 100 due to rounding.
*Response categories are based on DMAS staff analysis of responses to open-ended survey questions.

Stakeholder Issues and DMAS' Response

During the stakeholder process, several themes emerged as the most salient to providers; sampling methodology, the definition and use of a standard of substantial (versus 100%) compliance, and partial retraction. Each issue is discussed below.

Sampling Methodology

As discussed above, DMAS uses sophisticated data mining software to select providers for audits that ranks providers based on risk scores and then selects claims submitted by the identified providers. DMAS has focused reviews on providers that submit a large number of claims or bill for high dollars, in order to maximize efficiency. Up to fifteen months of claims are reviewed. Samples are non-random and are not used to create rates for extrapolation to the universe of claims from which they are drawn.

Stakeholder Comments

Stakeholders expressed the view that targeting large volume providers results in the same providers being audited repeatedly and suggested that small as well as large providers be included in reviews for both financial and safety reasons. They requested that the process to select providers for review be a random process, voicing concern that small providers may never receive an audit if they are not included in the provider selection process. They requested that no more than five percent of a provider's claims be included in a review, that claims samples are selected randomly, and that reviewed claims go back no more than six months, unless there is evidence of fraud. Providers expressed that the use of a shorter time period would reduce burden in that a review going back six months could span two fiscal years, but the use of longer review periods could involve three fiscal years. They requested that audits involve a maximum of two fiscal years.

DMAS Responses to Stakeholder Comments

DMAS is willing to consider the first suggestion that all providers should be subject to review, regardless of size or claims volume characteristics, although samples may continue to be targeted rather than randomly selected. And DMAS must continue to consider historical patterns associated with high risk when developing the audit plans, such as high volume, past involvement in fraud, a historic pattern of abuse, and verification by CMS of prior Medicare fraud. Second, true random sampling is employed in reviews in which the objective is to extrapolate sample results to the entire tested universe. DMAS is willing to consider the use of random sampling, if results are used to extrapolate error rates to all claims submitted by a provider during the review period. In using this method, a finding of ten percent error among claims sampled would result in the assumption that ten percent of all claims in the universe of claims were in error; therefore, ten percent of the total claims would be subject to retraction (DMAS notes that this option is not likely to be favored by providers).

DMAS may be willing to consider the use of a smaller, targeted (non-random) sample. But if claims are randomly selected, the sample must be of a size that insures that the sample accurately represents the universe of claims from which it is drawn. When using samples, it is common that sample sizes allow for a ninety-five percent confidence level (meaning that it is highly likely that the sample accurately represents the universe), and the number of claims in the sample varies, based upon the size of the

universe of claims from which the sample is drawn. The use of a fixed, small (5%) random sample, regardless of the size of the universe of claims, will greatly increase the risk that the sampled claims may not accurately represent the universe of claims from which they are selected and may therefore under- or over-represent the magnitude of compliance. It is conceivable that providers would not endorse the use of random sampling in conjunction with sample sizes that would have low confidence levels, given the greater risk that the sample would not represent all claims. In addition, the use of a fixed small sample size would likely not comply with generally accepted auditing standards and therefore be vulnerable to and invite challenge based on the methodology, regardless of the merit of the result and would require additional periodic validation to gauge the performance of the method. It is the intent of DMAS to be fair and accurate in the review process; therefore, DMAS must use methods that preserve the integrity and purposes of reviews, which are to verify that services are delivered appropriately and to ensure that public funds are used as intended. The use of too small targeted samples would increase the risk that providers who are out of compliance would be missed, and the use of too small random samples would increase the risk of inaccurately estimating error rates that are applied to the universe of claims.

Lastly, the reasons for using claims from a fifteen-month period are to ensure that services are being delivered that coincide with the individual's Plan of Care; that there is an adequate claims history to evaluate services that span longer time periods; and that evaluations, periodic re-evaluations and updates to the Plan of Care are being performed as required. DMAS is concerned that using a short time span would constitute a serious scope limitation which could easily lead to distortion of overall review results. If such a time period constraint were imposed for one provider type, for consistency, it would have to be applied to the review of all provider types. In short, all issues of review scope determination are dependent on the need to adequately address the varying objectives of each individual review; one size cannot adequately fit all. Although DMAS has reservations about shortening the audit period, DMAS is willing to consider the use of a twelve month period in utilization review and financial review and verification audits. But the use of a shorter review period would not affect the sample size used, and in cases where fraud is suspected, the review period would continue to be driven by the requirements of the investigation.

Substantial Compliance and Retractions

Overview

Except for instances where a provider has been determined bankrupt or out of business (in accordance with 42 C.F.R. § 433.318), federal and state law requires the Department to pursue recovery of any overpayment once it has been identified, and the Department must return the federal share of such overpayment to the federal government within sixty (60) days, whether or not the Department has recovered the overpayment from the provider (42 C.F.R. §§ 433.300(b), 433.312(a),(b); Va. Code § 32.1-325.1(B)). If the funds recovered by the state are less than the Federal share of the funds paid in error, the state is required to pay the difference using state general funds. Federal law

provides limited provisions for adjustments in the event the overpayment claim is settled for (or determined through the appeals process to be) less than the overpayment amount initially identified (42 C.F.R. §§ 433.316, 433.320).

The Department is authorized to issue rules, regulations and policies on program matters (42 C.F.R. § 431.10(e)(1)(i), (ii)). Pursuant to such authority, the Department has promulgated regulations and published policy manuals. DMAS requires that all claims be compliant with all applicable documentation specified in regulations and/or provider manuals. Claims are found non-compliant if they meet criteria for over utilization and overbilling and when documentation is insufficient to demonstrate that services were delivered according to DMAS requirements and consistent with required the Plans of Care.

DMAS retracts for the number of units found to be out of compliance, based upon documentation and billing practices. For example, personal care aide notes document a one-week period but may be paid on a monthly basis. A provider could bill four units on one claim representing four week's of service. If upon review it was found that documentation was deficient for one of the four weeks, DMAS will retract payment for the one week that is in error. Further, if the review found that documentation of a criminal background check was lacking for the entire four week period, payment would be retracted for the entire four weeks. DMAS requested that stakeholders submit examples where retractions have included units for which documentation was in compliance, but has not received any to date. DMAS practices are similar to the majority of states that responded to the state survey. The results showed that the large majority of states that responded to the survey reported using a standard of one hundred percent compliance with documentation requirements. [4]

Stakeholder Comments

Stakeholders expressed various views regarding the use and definition of a substantial compliance standard. Suggestions submitted by stakeholders include the following:

1. Records should be held against a standard of substantial compliance versus a one hundred percent compliance standard, and retractions should be assessed only when the provider is not in substantial compliance.

[4] Follow-up phone calls were placed to states the six states that indicated that they used some definition of substantial compliance. New York reported that if errors, such as forms not dated, are found on three percent of the sample of 100 claims, the state drops the review. Also, NY extrapolates error rates of samples to all of a provider's claims over a two year period for recovery purposes. Texas indicated that the reviews for which substantial compliance apply are the quality reviews rather than compliance reviews. Other states did not respond in time to include in the report. . Iowa and Louisiana do not have a definition of substantial compliance. Louisiana determines compliance on a case-by-case basis and Iowa bases compliance on volume (e.g. if at least 51% are correct the state considers the provider to be substantially compliant). Note: based on the follow-up responses, it is possible that one or more of the states that did not respond to the follow-up inquiry might be using such standard for other purposes and not related to claims reimbursement.

2. Reviews should include consideration of a provider's intent to comply and should ascertain whether or not provider agencies have a compliance program in place that includes policies, procedures, training, monitoring and a system of internal controls where necessary corrective action is taken, suggesting that if an adequate compliance program were in place, retractions could be avoided.
3. In instances where documents conform to regulations and DMAS policy at least eighty percent of the time, providers should be found to be in substantial compliance with the requirements.
4. Substantial compliance should be based on trends or a pattern of non-compliance, rather than a single instance of non-compliance that causes full retraction of a week or month-based claim.
5. 42 CFR 455.23 provides authority for retracting a portion of the overpayments versus the entire overpayment.
6. Holding personal care aides to DMAS' documentation standards is difficult, because aides are hired based on their skills as service providers rather than their ability to write service notes, and the quality of documentation reflects the skill level of staff that can be hired at the current reimbursement rates.
7. DMAS should recognize accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) as evidence that providers are in compliance with DMAS requirements.

DMAS Response to Stakeholder Comments

In response to item one above, DMAS' view is that substantial compliance is difficult to implement for all requirements because errors impact care differently, and legal issues are involved. DMAS' current practice is to conduct reviews claim-by-claim, not in the aggregate. DMAS' practice of requiring full compliance with all requirements is in line with the practices of most states that responded to the state survey.

In response to the second item in the above list of stakeholder comments, the fact that a provider has put a compliance program in place does not guarantee that it is being followed, and a method to verify the efficacy of such a plan likely would involve reviewing records. While DMAS encourages in-house quality assurance efforts, the fact that deficiencies have been identified by the provider prior to a review by DMAS does not obviate the fact that payments may have been made by DMAS for transactions in error. In DMAS' view, the consideration of corrective action plans and compliance programs implemented by the provider may be appropriate during the settlement process.

In response to stakeholder comments three and four in the above list, DMAS is reluctant to apply a standard of substantial compliance across the board to violations of statutes, regulations and policy provisions. The Department is concerned that use of a lower standard, such as eighty percent compliance with all requirements, or the use of trends, may place Medicaid individuals in jeopardy. DMAS has a duty to ensure that individuals receive services that are safe and appropriate to their needs.

The regulation cited in item five of the above list of stakeholder comments is found in the Code of Federal Regulations, Part 455, Subpart A – Medicaid Agency Fraud Detection and Investigation Program. This regulation, as amended, states in part:

> *§ 455.23 Suspension of payments in cases of fraud.*
> *(a) Basis for suspension. (1) The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payments only in part.*

This regulation applies to instances where a credible allegation of fraud has been determined and requires states to suspend payments unless there is good cause not to do so. The application of this regulation is clearly limited to findings of fraud.

Regarding the sixth point expressed by the stakeholders concerning the skill level of personal care aides, DMAS' provider manuals specify certain requirements, including that personal care aides must have the ability to read and write in English to the degree necessary to perform the expected tasks. DMAS suggests that these are training and monitoring issues that are the responsibility of the provider. Despite the fact that a frequently cited review deficiency is a finding that the aide record did not contain required weekly or appropriate comments, the majority of aides' notes are found to be in compliance with DMAS standards when reviewed.

Item seven on the list of stakeholder comments concerns CARF accreditation. While there may be value in obtaining CARF accreditation, it would not meet the federal requirement for post-payment reviews per 42 CFR §456.23 cited above.

Conclusion

DMAS consulted with representatives of providers of home-and community-based and home health services concerning reviews of such providers and evaluated the effectiveness and appropriateness of review methodologies. As a part of the evaluation, DMAS surveyed other states to determine the degree to which DMAS practices comport with the practices used in other states.

DMAS concludes that the majority of compliance policies and standards currently used by the agency are effective in detecting instances of non-compliance, are appropriate for ensuring that individuals receive care that is safe and appropriate and that providers receive payments that are in accordance with DMAS requirements. DMAS practices are very similar to the practices used in other states that responded to the state survey. DMAS views the issue of substantial versus complete compliance standards as one that requires more thorough consideration of the practical and legal issues involved, as well as how it would impact safety, quality of care and program integrity.

DMAS concurs with stakeholders that the types of providers subject to review could be expanded to include all providers, regardless of size. In addition, DMAS is willing to explore the use of random sampling to extrapolate findings to the universe of claims, but does not endorse the use of a fixed five percent sample size, as this would increase the likelihood of producing results that are methodologically unsound, unreliable and would invite challenge. DMAS endorses the use of statistically valid sample sizes, in order to ensure that the sample accurately represents the universe of claims from which they are extracted, but will consider using sample sizes that are smaller than those currently used, when appropriate. DMAS does not endorse the use of a six-month review period, as this period does not provide the time span necessary to evaluate if care is being provided as intended, but will consider using a twelve month period. Lastly, DMAS will evaluate the feasibility of implementing process improvements suggested by stakeholders.

ATTACHMENT I

Appropriations Act Language

Item 297 AAAAA. The Department of Medicaid Assistance Services shall consult with representatives of home-and community-based care services concerning audits of such providers, and shall evaluate the effectiveness and appropriateness of the audit methodology. The Department shall submit a report on this evaluation to the Governor and to the Chairmen of the House Appropriations Committee and the Senate Finance Committee by November 1, 2011.

ATTACHMENT II

Stakeholder Participants

AFFILIATION	NAME
Virginia Association for Home Care and Hospice (VAHC)	Marcia Tetterton
	Vickie Morgan - Riverside Home Health
Virginia Association of Personal Care Providers (VA-PCP)	Olivia C. Jones
	Peggy Beasley
	Bonnie Gordon
Virginia Association of Community Services Boards (VACSB)	Dee Keenan – VA Beach CSB
	Beth Ludeman-Hopkins - Central VA CSB
	Jane Lewis - Region Ten CSB
Virginia Network of Private Providers, Inc (VNPP)	Jennifer Fidura
	Ann Bevan
Endependence Center Inc.	Maureen Hollowell
Virginia Association of Community Rehabilitation Programs	Karen Tefelski
	Dave Wilber
Virginia Adult Day Health Services Association (VADHSA)	Lynne Seward
	Jane Woods
	Dora Robertson
Virginia Day Health	Sue Rowland
Virginia Organizations Responding to AIDS (VORA)	Sue Rowland
ARC of Virginia	Jamie Liban
	Quintin M. Mitchell
	Cheryl Johnson
Virginia Association of Area Agencies on Aging (VAAAA)	Eldon James
Virginia Association for Hospices & Palliative Care (VAHPC)	Brenda Clarkson
	Brenda Mitchell

Department of Behavioral Health and Developmental Services (DBHDS)	Heidi Dix
	Lee Price
Department of Medical Assistance Services (DMAS)	Cindi Jones
	Scott Crawford
	Steve Ford
	Louis Elie
	Terry Smith
	Paula Margolis
	Gerald Craver
	Vanea Preston
	Jeanette Trestrail
	Tracy Wilcox
	Helen Leonard
	Adrienne Fegans
Facilitator	Charles Lawver

ATTACHMENT III

Audit Methodology Plan
August 24, 2011
10: a.m. – 12:00 p.m.
Minutes

- **Welcome and Introductions**

Cindi Jones, Director of DMAS welcomed group and asked for introduction of workgroup members. See attached list of workgroup members/staff attending.

- **Purpose and Scope of Meeting**

Cheryl Roberts, Deputy Director Programs, provided background on the purpose of the meeting as outlined in the 2011 budget. Regulations, that were asked to be revised in 2008, are currently in the Governor's office for review and approval. The Department also conducted a survey of other states and received input from our providers/associations on the process. DMAS is reviewing internal codes and processes as part of the methodology plan. Additional comments can be submitted to Adrienne Fegans at adrienne.fegans@dmas.virginia.gov

- **National Overview**

Gerald Craver, Sr. Research Analyst reported on a national survey of audit processes conducted by the Department. Results of the survey will appear in the final report in November. Workgroup members were provided with copies of the survey questions.

- **Virginia Audit Process**

Jeanette Trestrail, Manager Provider Review presented on audit requirements and the DMAS audit process.

- **Working Session**

Charles Lawver, Facilitator, led the discussion with topics of what works well and what can be improved in the audit process.

What is working well:

» Strides have been made in the QMR and now rate is 120%
» Automated process
» Technical assistance
» If providers have corrective action plan, staff willing to come back and work with provider
» Still have a way to go with regs and manuals
» Improvements in DMAS internal coordination
» Communication with providers prior to going to appeals
» Use of subject matter experts
» Auditors are helpful with the opportunity to correct/clarify
» Medicaid willing to work with providers to clarify
» Initial audit dialogue good
» People of integrity trying to be responsive to clients and the Commonwealth
» Some things in the process have changed based on input
» Sense of shared responsibility to tackle issues

What is not working:

- Timeliness of feedback on audits – 6 months later is not helpful
- Dialogue with providers stops after initial contact and difficult to get a response
- Auditors ask for little clarification/documentation
- Auditors have little medical background
- Dialogue during review is not good
- Minimal time in exit conference
- Expectations and communications between providers and auditors not clear – need training
- Auditors need to get clarifications while on site
- Lack of clarification of terms/definitions of fraud, waste, abuse, error and improper payment – need a glossary that is universally applied and outlined in regs
- Can we reasonably comply with 100%?
- Struggling with reasonableness standard to meet compliance (e.g., weekly notes)
- If things have been fixed, all providers need to know
- Discrepancies on the use of tools which results in having to keep two sets of records (one for DMAS and one for DBHDS)
- 100% standard is unreasonable
- Personal care providers struggle with process and compliance and are only ones held to 100% compliance and retraction
- Definition of substantial compliance threshold and documentation
- Letters from contractors unclear re: time frame, etc
- Hard to have communication when desk audit conducted – better rapport with on-site audits
- Use of EHRs – there is not a lot of interest on the part of auditors to use technology to obtain information/documentation vs. boxes of paper
- Auditors unfamiliar with person-centered planning and DD waiver mechanisms

Workgroup would like to have:

- Training for providers with DMAS (not solely with DBHDS)
- Checklist for QMR
- Last 2 versions of manuals archived on DMAS website
- Drill down into responses from the state survey
- Identification of overturned court audits
- DMAS needs specific examples of 100% take back for extended periods of service
- Providers need to understand specifically what DMAS needs for evidence

Retractions:

- Providers have issue with standard of substantial compliance
- LTC providers who bill for an extended period of time have complete retractions if information is missing for one day

- **Next Steps**

Next Meeting: September 12, 2011 9:30 am – 12:00.

Topics members would like included in next discussion:

- Partial retraction vs. 100% retraction
- Definition of substantial compliance
- Assurances that policies fit the regs for audits – quality check
- Use of technology
- Consistent application of regulations
- Expectation of auditors
- Threshold for 100% compliance

- Allowance for errors
- Payback on errors
- How audits are pulled initially
- Communication on federal audits
- Desk audit – timeframe for pulling and shipping documentation and the volume of records and the impact on providers – need to analyze
- Delineation of what was in the past, current process and what is expected in future
- Deeming with accreditation policy
- Training and technical assistance

ATTACHMENT IV

Virginia Department of Medical Assistance Services
State Medicaid Program Integrity Home and Community Based Services
Provider Reviewing Methodology Survey Questionnaire

INSTRUCTIONS: Please provide all requested information in the spaces provided. For this questionnaire, home and community based services refer to agency- or consumer-directed personal care, home health, respite, and hospice services.

Name/Title: _____

State: _____ Date: _____

Phone Number/Email Address: _____

START HERE

1. **Are reviews conducted based on different types of home and community based service (HCBS) providers?**

   ☐ Yes
   ☐ No

2. **Are certain types of HCBS providers excluded from reviews?**

   ☐ Yes
   ☐ No (Skip to question 3)

   2a. If yes, which types of HCBS providers are excluded from reviews?

3. **How many months of service claims data are examined during the HCBS provider reviews?**
   _____ months

4. **What data mining software does your state use to review claims data when reviewing HCBS providers?**

5. **Does your state randomly select claims to review when reviewing HBCS providers?**

   ☐ Yes → *(Skip to Question 7)*
   ☐ No →

   5a. (If No) How does your state select service claims to review when reviewing HCBS providers?

6. **What percentage of service claims does your state select for review?**
   _____ Percentage

7. **How does your state determine sample size when selecting service claims for HCBS provider reviews?**

8. **Does the sample size of service claims selected for review differ depending on the type of HCBS providers that are reviewed?**

☐ Yes
☐ No

8a. (If No) Does the sample size of service claims differ based on other criteria?

☐ Yes
☐ No

8b. (If Yes) What other criteria are used to sample service claims during review reviews?

9. **What process does your state use to perform review runs on claims when reviewing HCBS providers?**

   ☐ Automated claims data runs
   ☐ Chart reviews
   ☐ Complex review runs (i.e., automated and chart reviews)

10. **Does your state perform on-site or desk reviews on HCBS providers?**

    ☐ On-site review reviews
    ☐ Desk review reviews
    ☐ Both on-site and desk review reviews

11. **Does your state perform announced or unannounced reviews on HCBS providers?**

    ☐ Announced review reviews
    ☐ Unannounced review reviews
    ☐ Both announced and unannounced review reviews

12. **Which type of staff does your state use to perform review reviews on HCBS providers (*check all that apply*)?**

    ☐ Recovery review contractors (RAC),
    ☐ Medicaid integrity contractors
    ☐ In-house staff

13. **Does your state review service claims that are billed for all types of units (e.g., per unit, by minutes/hours, by week, by month) when conducting reviews?**

    ☐ Yes
    ☐ No

    9a. (If No) What types of units are not subject to review?

14. **Are review results from service claim samples extrapolated to all of a provider's claims for recovery purposes or are recoveries limited to claims that were actually reviewed during the review?**

    ☐ Claims are extrapolated to all of a provider's claims for recovery purposes
    ☐ Recoveries are limited to claims that were actually reviewed during the review

15. **For services for which the unit of service is a week and/or month, if any part of the plan of care is not followed (e.g., five physical therapy services were provided but the care plan called for seven), does your state recover the entire claim amount or a only portion, based on the level of service that was delivered?**

☐ Entire claim amount is recovered
☐ Only a portion of the claim amount is recovered

16. **Does your state consider a service claim to be out of compliance if a required signature or date of signature is missing from the claim?**

☐ Yes
☐ No

16a. (If Yes) If a service claim is found to be out-of-compliance, but a documented corrective action plan is in the individual's record, does your state include this claim in the recovery process?

☐ Yes
☐ No

17. **Does your state require <u>all</u> claims from HCBS providers to meet all documentation requirements, or does your state allow provisions for <u>substantial compliance</u> (e.g., 75% of claims must have all required supporting documentation)?**

☐ <u>All</u> claims from HCBS providers must meet all documentation requirements
☐ A <u>substantial number</u> of claims from HCBS providers must meet all documentation requirements

13a. (For Substantial Compliance) What is your state's definition of substantial compliance?

18. **Are providers allowed to request a review of <u>all</u> their claims during an appeals process (versus a sample of their claims) in order to demonstrate substantial compliance or compliance?**

☐ Yes
☐ No

19. **Does your state allow HCBS providers to conduct self reviews?**

☐ Yes
☐ No

20. **Does your state require HCBS providers to pay for reviews?**

☐ Yes
☐ No (skip to question 18)

21. **If your state requires providers to pay for reviews, how is the fee determined?**

22. **Are recoveries from HCBS providers tied to Quality Management Reviews?**

☐ Yes
☐ No

23. **Has your state reduced reimbursement rates for HCBS providers within the last two years?**

☐ Yes
☐ No

24. **Has your state reduced benefits for HCBS individuals within the last two years?**

☐ Yes
☐ No

25. **Does your state have separate rules governing reviews of HCBS providers who provide services to persons with intellectual and/or developmental disabilities?**

☐ Yes
☐ No

25a. (If Yes) What rules does your state apply to reviews of HCBS providers who provide services to persons with intellectual and/or developmental disabilities?

26. **Please provide any additional information regarding your state's review process of HCBS providers that were not addressed in the previous questions in the space below.**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

ATTACHMENT V

Stakeholder Comments

- Do not define Substantial Compliance (SC) by looking at a percentage of the aides' patient notes that were properly done. Instead, determine if processes are in place to ensure that the work was performed. For example, with a criminal background check requirement, determine if there is a procedure in place to ensure background checks are performed (i.e. there is an intent to comply). Ensure that a training program (provider training its employees) is in place. Ensure that staff compliance to requirements is monitored by the provider. Substantiate due diligence by determining if the provider identifies errors and performs (and documents) corrective action.
- For SC, there must be a trend or a pattern of non-compliance, not a single issue of non-compliance that causes a full retraction of the week or month-based claim.
- VACSB supports the following definition of SC, as provided to DMAS on September 7, 2011: "Documentation in any form that can support the logical conclusion that services were provided as billed and there exists no evidence that services were not provided as billed or are a result of fraudulent practices." SC means that training, policies, and procedures are in place. Not sure if there should be a percentage or predefined standard.
- There should be more discussion at the entrance conference of how the situations (possible issues or findings) will be handled.
- There should be consideration of substantial compliance to CARF standards. Current reimbursement rates for staff do not support higher level staff that would be able to document compliance more thoroughly. There are no standards for documentation.
- There will always be human error and that should be taken into consideration. An established process and communications with auditors can minimize conflicts.
- During the entrance conference, the providers may not be assertive enough to ensure their input into the process. Some providers should be included in developing the audit programs. Further, differences exist within the various types of service (ID Waiver, personal care, etc.) and those differences should be reflected in the various audit programs.
- On-site audits are more beneficial than desk audits.
- Clifton Gunderson (CG) comes into the provider's facilities, scans documentation, then goes back to the office to develop the findings.
- There was virtually no communication. CG scans charts and leaves. No questions are asked about the notes on the charts.
- There is a distinct difference between community-based services audits and institutional services audits. Community-based services are very unique.
- The audit program should be distributed out to the providers to help with their performance.
- Look at claims by unit of service. Claims are now for a period of time (such as a week or month) and if one day's documentation is missing CG does a 100% retraction, where Program Integrity tries to determine the portion of the claim affected by the missing documentation. This problem may have been resolved by

DMAS already, but the providers have not been informed if that is the case. We would like to see better communication of changes to the providers.

- Our audit involved a full claim retraction and we were unable to determine how the retracted amount was calculated from the information provided. Providers need complete explanation of the retraction because it is difficult to understand CG spreadsheets.
- An audit originally asked for $700,000 to be returned. It was finally settled for $30,000. CG does not provide enough explanation for the finding amount. There should have been more detailed information about the finding and amount questioned in the audit letters.
- The letters still do not contain sufficient information about the findings and retraction amounts.
- On-site audits with ongoing dialog help the audits. The audit program should be a collaborative effort between DMAS, CG, and the provider community.
- The preliminary and the final audit end up being the same. Encourage DMAS to ensure that the providers have a copy of everything the auditors copied and took with them for off-site review.
- The specificity that is required by the auditor on the preliminary or final letter should be a standard.
- Complete claim retractions have been an issue.
- SC for training documentation / ID training. What happens if one day's training record is missing?
- Define SC based on unit of service rather than mechanics of billing.
- Keep in mind the qualitative vs. the mechanics of billing.
- Some auditors have to be educated by the providers because they have no waiver services background. Educating the auditors is not always well received.
- As we move toward electronic records, we need to know how audits will be handled in the future.
- We are totally automated. How much training time are we going to need to devote for the auditors?
- The ID and DD community have not had training since 2005/2006. In that training, exercises were critiqued and we were told how we could improve responses for audits. This type of training would be helpful.
- How does DMAS define "policy"?
- From the provider community it would be easier to swallow if it did not feel like a "gotcha". We want to know the rules we must play by. DMAS should publish or post to the web site information like: what is DMAS' audit cycle this year; who was selected for PERM audits; and what are the PERM audit results.
- Some CSBs have been using electronic records for several years. Some conversation needs to occur on how this will affect audits. There is a need for a DMAS portal to submit electronic records requested for audits. It would be helpful for the community to have input into the Secretary's plan for HIE.
- Look at ways to do audit electronically rather than using paper.

- Need to know what regulations are being used. Emergency regulations are no longer in effect, reverted to older regulations. How are providers supposed to know which regulations which apply to each audit?
- Providers are the largest employers in many areas of the state. Excessive regulations are destroying jobs in Virginia. Providers should not be forced to adhere to a standard that is unattainable.
- Please continue to work with providers on this issue.
- Change regulations, which are at the root of the problem. Change the DMAS 90 – instead of using a weekly narrative use checkboxes. If a change in the individual's condition occurs, an item will be checked "yes" and this will trigger a report to the agency. Often an individual's condition does not change and a note to that effect should be sufficient.
- Costs continue to go up, rates are going down and community-based care is increasingly important. What is the vision? Improve community based services. Providers are being asked to increase capacity while serving a more challenging population. Retractions can make me lose my business and my home and require that I lay off 200 plus employees. Audits are expensive in time and effort and the economic environment is challenging. Improve collaboration between agencies (DMAS, DBHDS, and VDH). Providers should have competency review at business start up and no further audits.

ATTACHMENT VI

Written Communications from Stakeholders

From: VNPP [vnpp@earthlink.net]
Sent: Wednesday, September 07, 2011 4:05 PM
To: Adrienne Fegans
Cc: Ann Bevan
Subject: Audit Methodology Homework

VNPP would suggest the following elements for a definition of "substantial compliance:"

- Systems are in place to comply with the requirements
- Training is done as appropriate
- Compliance is monitored
- Errors are identified and resolved

We are not clear about why a method for determining substantial compliance would be necessary in the regulations; it should become a part of the audit protocol when it is established just as other items which may or may not be reviewed are part of the protocol.

We would also suggest that "partial retraction" is not the term to be defined; that term was used only to give a "name" to the following concept:
Retractions are done only for the portion of the claim which was

- not an allowable service/activity
- not properly documented, or
- was provided by an unqualified individual

This is the method which appears to be consistently employed by DMAS staff, but has not always been employed by the contract auditors.

We have cooperated in a small survey to get examples of misapplication of regs -- I'm sure you will be getting that information soon

I hope this is helpful and answers our "homework" questions!

Jennifer
Virginia Network of Private Providers, Inc.
804 Moorefield Park Drive, Suite 201
Richmond, Virginia 23236
804-560-4640

Brenda Clayton

DMAS Audit Concerns.

(1) Failure to communicate the true intent of the audit, either over the telephone or in written communication. The term "Program Integrity" was never mentioned.

We have participated in 2 previous Clifton Gunderson audits in the past 10 years, one on site and one desk audit. Both of those audits were comprehensive examinations of our financial and billing activities, focused on identifying billing errors, overpayments, authorizations in both routine and "bed bill" Medicaid claims. We understand the need for ensuring that we are processing claims according to regulatory requirements and taking corrective actions when errors are found. At no time during our one phone conversation with Clifton Gunderson staff regarding the recent audit, or in the subsequent letter or fax, was there any indication that the substance and content of this audit process had changed drastically since our last review.

(2) Lack of clear communication concerning the volume of data that would be required to achieve the audit objectives.

During the previous audits, patient information was reviewed in a sample setting and primary focus was placed on financial activities and billing accuracy (essentially an audit in a clear sense of the word). This audit, however, required us to provide all clinical patient notes, care plans, and authorizations over a 15 month period for the selected patients. This was not a random sampling of the audited period (as is customary in an audit setting) but of all documentation. This resulted in such a large volume of documentation that we could not print all of it. For example, one patient had 667 pages of visit notes alone. The financial analysis the auditors performed while on site was minimal, taking just a few hours the first day. The balance of their time was spent collecting clinical data and downloading selected documents from employee personnel files.

(3) All clinical and personnel data requested was downloaded to the auditors' computers and carried offsite.

Once we had provided the auditors with the data requested on a flash drive, we assumed they would begin a review of the data and make an analysis of findings as they went along. In our initial meeting, however, we were informed that they would be downloading all of the data we had provided as well as scanning any other paper documents they would deem necessary during the audit process into their computers. This was when we became aware that this was not an audit in the sense that they were here to perform a standard sampling analysis of financial activities. This was more in the character of a licensure or Medicare survey, with some additional disturbing features. Even in a licensure or Medicare survey we do not have patient data removed from the office site. Data is reviewed on site, and, notes and problematic areas identified and reported.

BUILDING COMMUNITIES OF FAITH AND LIFELONG HOMES
WITH PEOPLE WHO HAVE INTELLECTUAL DISABILITIES

September 26, 2011

Department of Medical Assistance Services
ATTN: Review of Medicaid Audit Methodology, Item 297(AAAAA)
600 East Broad Street
Richmond, Virginia 23219

Re: "Substantial Compliance" Standard for Medicaid Audits

Dear Sir or Madam:

We are writing to request that DMAS adopt a "substantial compliance" standard as part of its Medicaid audit methodology. As you know, DMAS is presently reviewing its Medicaid audit methodology pursuant to Item 297(AAAAA) of the 2010-2012 budget for the Commonwealth of Virginia. Item 297(AAAAA) requires DMAS to "consult with representatives of providers of home- and community-based care services . . . [and to] evaluate the effectiveness and appropriateness of the audit methodology." For reasons discussed below, we believe that DMAS should adopt and apply the same sort of "substantial compliance" standard with respect to supporting documentation required for Medicaid audits that both DMAS and CMS have applied in other Medicaid contexts.

L'Arche Greater Washington, D.C. is a 501(c)(3) nonprofit organization that provides community-based residential services for persons with intellectual disabilities, enabling members to live with dignity, form strong relationships, and exercise independence and self determination. L'Arche operates four community homes in the D.C. area, including two in Arlington, Virginia. L'Arche has been recognized by government leaders in the District of Columbia and Arlington County as a model for the provision of housing services for adults with intellectual disabilities. L'Arche Greater Washington, D.C. is one of seventeen L'Arche communities nationwide, which which also include Medicaid provider L'Arche Blue Ridge Mountains in Lynchburg, Virginia.

Reimbursements received from the Virginia and D.C. Medicaid programs provide nearly 70 percent of L'Arche's annual operating budget. L'Arche depends on adequate Medicaid reimbursements in order to furnish the vital services it provides to its residents and the community.

I. The Problem

1. L'Arche's Audit Experience

L'Arche's own experience with the DMAS audit process has been disquieting. L'Arche was audited in January 2007, just five months after the first Arlington, Virginia L'Arche home opened its doors on August 28, 2006. The auditor assessed an overpayment in excess of $14,000 due to an alleged deficiency in the individual service plan ("ISP") for one L'Arche resident for the 60-day assessment period that began on August 29, 2006, the day after the home opened. There was abundant evidence in the resident's medical record related to the ISP. In addition to the ISP itself, there were detailed progress notes made during the 60-day period covered by the ISP. The record also included an approved and dated Individual Service Authorization Request ("ISAR") that authorized the 60-day assessment pursuant to the ISP.

Nevertheless, because the ISP itself did not specify a "start date" and an "end date" on its face, the auditor asserted a lack of documentation confirming the time period to which the ISP applied. The auditor refused to consider the incontrovertible evidence elsewhere in the resident's record that confirmed the time period. Namely, the approved ISAR for this same ISP contained an official notation by the Virginia Department of Behavioral Health & Developmental Services (DBHDS)[1] that said, "approved, assessment period 8/29/06 – 10/28/06."

Despite an inability to point to any clear regulatory or manual requirement that L'Arche had violated, the auditor entered an adverse determination. The auditor was completely uncommunicative, repeatedly ignoring L'Arche's request for an explanation of the basis for her decision. In fact, L'Arche did not learn the reason for the assessment until the informal fact-finding conference. Although L'Arche eventually prevailed on appeal, and had the overpayment determination reversed, the lengthy, stressful, and costly review process was an entirely unnecessary and inefficient drain on resources for both L'Arche and DMAS.

2. What We Are Asking

Experiences like ours illustrate the need for auditors to embrace a more rational approach to Medicaid audits. Ours was not a situation in which there was any question whether the beneficiary's health and safety were placed at risk, or whether the provider was billing for services that were never provided or were not covered, or whether payment should appropriately be made to the provider and not some other party. Indeed, had the auditor looked at the resident's medical record as a whole, there could not have been any question that medically appropriate, covered services were furnished to an eligible beneficiary, by properly trained personnel, and that the treatments complied with Medicaid's high quality of care standards. This

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[1] DMAS and DBHDS, which, at the time of L'Arche's audit was called the Department of Mental Health, Mental Retardation and Substance Abuse Services, operate under an interagency agreement whereby DBHDS authorizes ISARs as a delegated function from DMAS.

is the type of situation we are talking about. For situations like this one, DMAS should reform its Medicaid audit methodology to enable providers to overcome immaterial deficiencies in documentation by furnishing additional documentary evidence to supply the missing information.

When auditors review records in the sort of inflexible, mechanical way in which the auditor proceeded in the first audit of the Arlington home, gross inefficiencies are unnecessarily interjected into the system at the expense of both DMAS, the providers, and the beneficiaries. The auditor's failure to consider the totality of the evidence furnished deprived her of a complete and accurate understanding of the services provided. In L'Arche's example above, any rational reviewer examining that medical record would have concluded without difficulty that the dates printed on the authorization notice applied to the ISP that it authorized. Having been hamstrung by an inflexible audit blueprint, however, the auditor focused exclusively on that single piece of paper with tunnel vision, and went mechanically down her checklist, losing sight of the forest for the trees in the process.

We are not asking DMAS to lower its standards. We do not dispute the obvious need to ensure that providers comply with the Medicaid conditions of participation and that providers accurately and completely document services for which reimbursement is claimed. We merely suggest that audits should not be conducted in such a mechanical way, resulting in the denial of reimbursement despite ample evidence that reimbursable services were furnished and that the provider is making a strong, consistent effort to comply with all agency requirements.

The Federal government is very focused right now on ferreting out fraud and abuse in the Medicare and Medicaid programs and on the recovery of what it terms "overpayments." *See, e.g.*, Affordable Care Act, Pub. L. No. 111-148, § 6411(a) (Mar. 23, 2010). Situations like the one we're describing—where auditors are reclaiming reimbursements on the basis of immaterial, trivial recordkeeping errors, despite clear evidence that covered services were provided—are not "overpayments." CMS has explained that "overpayments" occur as a result of duplicate billing, payment to the wrong person, or payment for excluded, non-covered, or medically unnecessary services. *See* The Medicare Overpayment Collection Process Fact Sheet, ICN 006379 (July 2011), *available at* https://www.cms.gov/MLNProducts/downloads/OverpaymentBrochure508-09.pdf. There can be no dispute that fraudulently obtained payments and payments made in error for non-qualifying services should be recovered by the government. These simply are not the types of situations we're discussing.

II. DMAS Has Authority to Fix The Problem

Nothing in Federal or State law requires DMAS to apply an inflexible and mechanical approach to Medicaid audits. Although State Medicaid plans are required by Federal statute to conduct post-payment audits in order "to ensure the proper and efficient payment of claims and management of the program," SSA § 1902(a)(37)(B), Federal law does *not* prescribe the *methodologies* that States must employ in conducting these mandatory audits. Audits must, of course, include "review of appropriate data," *id.*, but each State establishes its own rules and

audit procedures. Accordingly, CMS regulations speak only in general terms, simply requiring States to establish methods for identifying instances of suspected fraud (42 C.F.R. § 455.13(a)), and conduct investigations of questionable practices (42 C.F.R. §§ 455.14, 455.15). *Accord* 12 Va. Admin. Code. §§ 30-10-440 and 441.

DMAS is responsible for establishing and maintaining compliance standards for Medicaid providers in Virginia. *See* SSA § 1902(a)(9)(B). Although DMAS does not begin with a blank slate in defining these standards—the broad brushstrokes are painted by Federal law—the details are squarely within DMAS's purview to determine. States are required to ensure that claims are paid properly, of course, but the evidence that auditors are permitted to consider is not circumscribed by Federal statute or regulation. DMAS certainly has the ability to develop an audit rubric that rationally takes account of all the evidence presented.

III. DMAS Should Fix The Problem

DMAS should establish an audit methodology that requires auditors to consider the full body of evidence presented by the provider in order to determine whether the provider has "substantially complied" with applicable documentation requirements. In situations where there is no question that covered services were furnished to an eligible beneficiary by an appropriate caregiver, and there is no risk to patient health and safety, a "substantial compliance" standard would enable providers to overcome trivial and immaterial documentation errors without having to pursue appeals that drain additional resources from both providers and DMAS and unnecessarily divert their attention from the critical missions that both the agency and providers are meant to perform. Ensuring that providers are appropriately reimbursed for the services they furnish would, in turn, benefit beneficiaries and the Medicaid program as a whole by fostering the growth of much-needed services within communities.

1. The Problem with "Strict Liability"

In the arena of Virginia's Medicaid audits, "strict liability" has come to mean "pristine documentation." Holding providers to an inflexible "strict liability" standard undermines the goals of the Medicaid program by reducing payments to providers for medically necessary services that were furnished in accordance with Medicaid's high quality of care standards. This, in turn, results in less money for providers to hire caregivers, thereby reducing the numbers of available jobs and inhibiting providers' ability to attract high-quality employees. The "strict liability" standard as it has been applied by DMAS auditors in situations like L'Arche's own audit, described above, ultimately results in fewer services for people with disabilities and is, in this way, unfairly discriminatory. Ultimately, it also diverts attention and resources of the agency as providers are required to pursue appeals from unsustainable disallowances.

This type of regimented, narrow-focused approach to provider audits is unnecessary to achieve high-quality services. These nitpicky, "gotcha" types of audits are not conducive to evaluating the meaningful elements of quality care. Human error is inevitable, particularly when

one is faced with a regulatory scheme as complex as Medicaid. Providers should not be unduly penalized for trivialities.

2. *Defining "Substantial Compliance"*

CMS and the Commonwealth of Virginia already apply a "substantial compliance" standard, within the context of Medicaid, for purposes of evaluating compliance with various conditions of participation by nursing facilities. CMS has defined "substantial compliance" in this context as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301; *accord* 12 Va. Admin. Code § 30-20-255(A). Under the Virginia Department of Behavioral Health and Developmental Services' "substantial compliance" standard for children's residential facilities, "there may be noncompliance with one or more regulations that represents minimal risk" when "compliance clearly and obviously exists with most of the regulations as a whole." 12 Va. Admin. Code § 35-46-10; *see also id.* at § 35-46-60(A).

Borrowing from these definitions, and other Virginia Code provisions that use a "substantial compliance" standard,[2] we offer the following working definition of "substantial compliance" in the context of Medicaid post-payment audits:

> A Provider is in "substantial compliance" if:
>
> (1) medically appropriate, covered services were in fact furnished to an eligible beneficiary in accordance with Medicaid quality of care standards;
>
> (2) the Provider acted in good faith without willful disregard of Medicaid requirements; and
>
> (3) any identified deficiencies caused no more than minimal risk to beneficiary health and safety.

Finally, in order for a "substantial compliance" standard to work, it is imperative that the provider be given an opportunity *during* the audit process to furnish alternate or additional evidence that can supply any missing information and otherwise support the delivery of the covered services in question. Too often in the past, auditors have formulated an incomplete understanding of the record and entered an adverse determination without first circling back to the Provider to ask questions. This back-and-forth process is essential, as it affords the provider the opportunity to resolve misunderstandings without necessitating formal appeals, which

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[2] "Substantial compliance" standards appear throughout the Virginia Code in the context of procedural requirements for handling blood and breath samples, Va. Code Ann. §§ 46.2-341.26:11 (Virginia Commercial Driver's License Act); *see also* 18.2-268.11 (Crimes Involving Health and Safety, same); procedures for review and assessment of sexually violent predators, Va. Code Ann. § 37.2-905.1; and procedures for drafting an "explanation of surplus or deficiency," Va. Code Ann. § 8.9A-616(d) (Virginia's commercial code for secured transactions).

expend considerable resources on both sides. Communication is the cornerstone of a workable "substantial compliance" standard.

* * *

We greatly appreciate the opportunity to participate in this discussion. We urge DMAS to reform its Medicaid audit methodology by adopting a "substantial compliance" standard, which would require auditors to consider all available evidence in the record, thus enabling providers to overcome immaterial documentation errors by furnishing additional documents to supply any missing information. If you have any questions about the comments expressed in this letter, please feel free to contact Steve Keener at (202) 232-8477.

Sincerely,

John M Cook

John Cook, Executive Director
Steve Keener, COO and General Counsel
L'Arche Greater Washington, D.C.

Bonnie Ford

Suggested Changes to DMAS 90

WEEKLY COMMENTS AND OBSERVATIONS:

Answer each question by checking the applicable box.	Y	N
1. Did you observe any change in physical or emotional condition?		
2. Was there any change in the need for ADL assistance?		
3. Did recipient or family have any concerns about or make any requests regarding the need for changes in their services?		
4. Did anything happen that you think your nurse supervisor needs to know?		

Explain each question answered YES: _____

_____

_____

_____

RATIONALE FOR REVISION:

This revision will trigger each aide to focus on important, reportable information and assure compliance with regulatory guidelines. Moreover, if something unanticipated has happened, or there is a change in the recipient's condition, each question that is anwered "yes" will trigger its report to the provider agency. If there are no changes or problems and everything went well, then the agency will not be at risk for a payment retraction based on a retrospective, subjective review of a comment that indicates there were no significant occurrences.

The condition of many recipients of personal care services does not change, and their need for ADL assistance is the same for long periods of time. In fact, DMAS states that the annual nursing review of a plan of care does not require the plan be rewritten, rather it only needs to be re-dated and re-signed to confirm its review and that no changes were necessary. Given this, it is unnecessary to require the current narrative on a weekly basis by aides for the purpose of assuring that health, safety and welfare issues and needed changes in care are being addressed. Since typically RNs review aide records on a monthly basis, this documentation should structure a prompter reporting mechanism, thereby increasing recipient safety.

VIRGINIA ASSOCIATION FOR
HOME CARE AND HOSPICE
Advocacy. Education. Guidance.

Home Health
Hospice
Private Duty
Medicaid Personal Care
Medicaid Skilled Home Health
Infusion Therapy
Companion Services
Durable Medical Equipment
Pharmacy
Case Management
Consultants

September 27, 2011

Cheryl Roberts, Deputy Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

RE: Utilization and Review Audits of Community Based Care Providers

Dear Cheryl:

As a follow up to our meeting of September 26, 2011, I have been unable to identify any CMS policy, regulation or federal statute that requires every documentation error must result in a 100% payment retraction for the period the documentation covered. In addition, I am unable to identify this requirement in state law.

By copy of this letter I am, again requesting the specific regulation or law that DMAS relies upon for this statement.

As you know, we have had a number of conversations regarding units of services and claims. A unit is individual or discrete part of a claim which can be divided, especially for analysis For example, a unit would be the preauthorized number of personal care hours for a given day. As a practical aspect and with direction from DMAS providers have been encouraged to submit CMS-1500 claims as a combination of units for an extended period of time. This "claim" is also referred to as an invoice in DMAS manuals. I trust this provides some additional insight and warrants serious consideration.

Sincerely,

Marcia A. Tetterton, MSG, CAE

8001 Franklin Farms Drive, Suite 110, Richmond, VA 23229
(804) 285-8636 | FAX (804) 288-3303 • email vahc@vahc.org | www.vahc.org

Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

Input for DMAS Audit Methodology Meeting
From VACSB Representatives
September 12, 2011

PURPOSE

To provide input from VACSB/CSB representatives on issues related to current DMAS auditing practices. Specifically to address questions regarding terms such as "substantial compliance" as raised during the discussion on 8/24/11 during a meeting in Richmond between DMAS and provider representation.

DISCUSSION

1. CSBs welcome an audit process that ensures the safety and quality of service delivery for consumers/recipients, many of whom have fragile conditions, and demonstrates benefit to the consumers. We support eliminating fraud, waste and abuse from the Medicaid system in the Commonwealth and across the nation.

2. Federal and state public policy can be experienced by providers as not fully coordinated and providers can feel a bit "in the middle" among varying sets of regulations An example follows:

    - While public policy and person-centeredness supports DBHDS requiring that providers of ID Waiver services complete the *SIS Assessment* as the primary source of information for *Person-Centered Planning,* DMAS does not accept the SIS as the functional assessment tool. As a result, providers have to complete two assessments to satisfy these requirements, which take a corresponding toll on the consumer and family. Unless the audit framework in some way honors the SIS elements and encourages person-centered direction in service delivery, audits can become confusing and providers may be making choices in policy direction that may carry penalties for them.

    (In January of 2009, the article in the *OIDS Community Bulletin* stated that CMS was a part of the grant funding for the initial stages of the *Person Centered Planning* project, so it is concerning that audit methodology does not support the use of the SIS tool, or at least consideration of its use, since SIS is a critical part of this person-centered model).

OFFICE OF INTELLECTUAL DISABILITY SUPPORTS
COMMUNITY BULLETIN #1 - JANUARY 2009

Person-centered thinking (PCT) is critical to the successful implementation of person-centered planning. Leadership from the Partnership for People with Disabilities, in collaboration with OIDS, has provided Virginia with several years of grant funding from the Centers for Medicaid and Medicare Services (CMS) for consultation and training in the implementation of PCT as developed by Michael Smull et.al. (Support Development Consultants).

3. As to the definition/protocol and goal of *Substantial Compliance*:

   a. *Substantial Compliance* is practice, within the field, at the level of quality that assures that providers are delivering the services for which they are billing. One definition or protocol might be "Documentation in any form that can support the logical conclusion that services were provided as billed and there exists no evidence that services were not provided as billed or are a result of fraudulent practices." Substantial Compliance is based on good faith attempts to meet specific criteria as required in DMAS standards. Substantial Compliance and partial retraction are defendable if the service is provided in good faith, proven to be medically necessary, supported by policies that promote quality improvement, appropriate training is conducted, and errors are identified and quickly resolved.

   b. This definition or protocol should become part of the audit methodology and could provide the same audit standards currently used, but with more flexibility in determining the overall compliance picture of an organization.

   c. This auditing practice could include the weighting of required documentation elements to show substantial conformance. For example, an unsigned note might not be as critical or as highly scored as another element (such as a completed assessment) to ensure that the service was delivered.

   d. A higher percentage score of the provider might be sufficient enough for due diligence and substantial compliance. Due diligence is a standard that is philosophically included in federal regulations related to the understanding of "Fraud, Waste and Abuse". (Even in the federal regulations, there are levels of conformance, depending on the intent to defraud vs. the unintentional compliance error.)

   e. We believe that providers who are intentionally defrauding the Medicaid system and preventing funding from being available for legitimate services to more recipients should be penalized. However, years of state and federal audits support that the largest proportion of providers continue to make every effort to meet all applicable compliance standards and requirements. Given this, the auditing approach should not assume or be one of intentional wrong doing on the part of the provider. If providers adopt the notion of compliance only and at all costs, it is possible that needed service delivery and quality may be sacrificed.

   f. As providers, our experience of the audit process is that it is often focused on the mechanics of documentation and not on the actual delivery of service or the quality of service provided to the consumer. For example, the issue of "was a signature dated?" can become more important than the overall delivery for the consumer.

g. Clearly the more important focus in service provision should remain - whether or not the service was delivered in a safe and effective manner as needed and directed based on accepted standards and best-practices, be an allowable service, delivered by a qualified individual, and properly documented.

RECOMMENDATIONS FOR THOUGHT AND CONSIDERATION

- Work with auditors regarding policy direction, person-centered planning and service implementation, and find ways with partner agencies to weave that federal and state policy direction into the audit framework.
- In previous years, DMAS provided CSBs with copies of DMAS specific audit sheets. These concise documents, in the form of checklists, helped to clarify complex service manuals. We encourage the return of this practice.
- Consider a system of "substantial compliance" for quantifying the measurement of the initial audit of a provider. Follow this level of audits with a more extensive, drill down audit for any provider that does not meet this level of conformance.
- Consider the overall compliance level/score of a provider meeting DMAS regulations as a better way to manage the distinction between mistake/misunderstanding and the need for punitive action.
- If a provider is found to be in substantial compliance but there are minor mechanics of documentation omitted or inaccurate, request a corrective plan of action as the solution.
- The current Medicaid focus on billing for a single disability area (MH/SA/ID) does not take into full consideration co-occurring realities that are being prioritized by CMS. In the future, discussions around the complexities of the disabilities and the billing realities should take place if Virginia is to stay on track with federal policy direction that providers are encouraged to adopt and practice.

As a result of this audit methodology process, we hope that providers will have clear communication about the subject matter of a particular audit, that staff time of providers, DMAS, and auditors are more efficiently used, and ultimately, that funding is dedicated to a service delivery system that is of high quality and effective.

The VACSB and CSBs believe that there is great benefit in continuing to develop the partnership and consultant role between DMAS and providers, so that audits are seen as mutually beneficial to providers, DMAS, and ultimately improve the quality of the service rendered to the consumer.

Substantial Compliance…Audit Methodology Assignment

One of the items that came up yesterday was the definition of substantial compliance and partial retraction. As noted, audits are based on regulations and policies. Since these "definitions" are not part of regulations, they are really not an audit issue, but rather a policy issue. Therefore, we cannot change the audit process. So I need your help. Prior to the September 12th meeting, I would like to receive input from each of you on what you would like to see in regulations and policy for the following:

Clear Standard Procedures:

a. Guideline's/check-list for compliance need to be specified and outlined for each provider type (case management, service facilitation, residential provider, etc.)…other than what's outlined in the manual?
b. Standardized forms would provide providers with a more consistent, standardized way that questions, conditions, auditing procedures, and interpretations are consistent and auditors would be able to administer the evaluation of services given in a more standard manner.
c. Examples within the policies of what is acceptable/not acceptable ex: case notes-----examples would alleviate "open for interpretation" in policy and regulations

1. Definition of substantial compliance: Substantial compliance is defined legally as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." Beverly Healthcare Lumberton v. Leavitt, 2009 U.S. App. LEXIS 16293 (4th Cir. July 22, 2009)

   Meeting all applicable Essential Standards and a minimum of (85 - 90) percent of the applicable Important Standards is reasonable and room for "human error" although defining what is essential and non-essential would need to be defined.

   In addition, to determine percentages, there needs to be a "check-list" for how to rate essential and non-essential areas.

   - Essential (full retraction after evaluating the percentage 85-90% human error): Documentation of case-notes/forms that monitor functional assessment of a client that provides supportive documentation to ensure that person's health and safety is maintained (residential (is it safe), medical (ex: nursing needs, special diet, allergies), mobility concerns, financial, etc. to also include plan of care to support medical necessary services ---this should be rated 85-90%. However, if the same mistakes are demonstrated on a continual pattern, a requirement would be for that provider go through re-training. The number of mistakes (how many is too many would also need to be determined and established).
   - Non-Essential and partial retraction (Case notes/documentations that are required by regulations but do not function as a health and safety risk to the person being served---should be rated at 85-90%) However, if the

same mistakes are demonstrated on a continual pattern, a requirement would be for that provider go through re-training. The number of mistakes (how many is too many would also need to be determined and established).

The concept of retraining being a part of the auditing process is essential because without this guidance, providers may not be able to receive proper guidance on how to prepare documentation and ensure that their clients are receiving the proper oversight. Part of the issue with providers receiving audits is that there often is not enough guidance in the agencies' foundations to ensure that they do not make these mistakes in the first place. In terms of essential and non-essential documentation, if one document is missing or missing a signature for a single day, it seems that the auditor should take other paperwork amassed over the totality of a larger unit, such as a month, into account.

Where a provider may almost always sign and initial documentation but if a few are missed it is not a payback. For the DD Waiver, we are required to have case-notes at least monthly and face to face contacts every quarter in our file (or at least supportive documentation for our billable units)...this is very different as compared to someone who renders services on a daily basis and has contacts/progress notes written daily…how does this percentage get evaluated…is the percentage by each case or by a number of case reviews.

- Case-notes: require provider's signature and date: this could evaluated by percentage
- Admin Docs from other service providers: ex: updated 225 form, 99 forms, evaluations, medication list, etc. should be counted as percentage, although there are some agencies where it's challenging to get the required updated forms even with best efforts and thus as long as the "challenge" of retrieving these docs is well documented, a retraction in payment appears harsh.

- Definition of partial retraction – non-essential items that would not otherwise impact an individual's health, safety, and personal care needs: Admin Docs. ex: updated 225 form, evaluations, medication list, social assessment, etc. should be counted as percentage, although there are some agencies where it's challenging to get the required updated forms even with best efforts and thus as long as the "challenge" of retrieving these docs is well documented, a full retraction in payment appears harsh.

How are these defendable in an appeal? 1) Documentation that a provider has met the 85-90% compliance rule based on meeting the essential/non-essential activities with the main focus that qualitative and quantitative services were rendered to the individual with the intentions of providing safe measures to the individual of which they would be protected from any health or safety risk.

How do the definitions address health and safety? Documentations that otherwise would indicate the protection of someone's health and safety and not the administrative items that do not pose and threat.

Send me examples from the past 2 years in which the contractor or DMAS auditors misapplied the regs (remember to send any PHI via secured email):

Quarterly reports are not always the same form as other providers and one auditor may interpret that the quarterly report does not have enough content outline to "count" versus another auditor might say the same quarterly report is fine. There needs to be **more standardized forms** being developed to understand what is meaningful content that will assist in guiding the service provider toward following more guidelines of compliant rules. *If a standardized form was developed, this issue should resolve itself. Also, what is expected to be written on specific forms that providers are asked to develop on their own is often open for interpretation whether they are meeting the guidelines setforth.*

Additional Notes

Point #1: Form Requirements: ***Impossible to compare apples with oranges:*** *Forms that are used to monitor if a provider is following policies/regulations needs to be more standardized for providers to use to help facilitate providers toward meeting the expectations and regulations. Ex 1: different waivers/service providers use different forms. How do we develop policies and regulations for different providers who render different services?*

Point #2: **Face to Face Requirement:** Code 708: 90 day requirement w/ 10 day grace period permitted if contact with the individual cannot be made within the 90 days because the individual is not available. **There is no protection for the case manager/service providers if there is inclement weather which otherwise might impact the provider from doing a visit that might other jeopardize the provider's safety. Ex: If a provider had supportive documentation (case-note) that indicated a visit could not be rendered due to a snow storm...and the storm lasted passed the 10 day grace period....could this be re-reviewed in policy and regulations for exceptions (also even after indicating that a visit could not be rendered for a specific date, an auditor still requests for a case note).*

Point #3: Code 704: The case management file submitted did not contain the required DMAS 122 form (now 225) for the date(s) of service billed. There must be a copy of the form 122 in the file and at least yearly updates of the DMAS 122 form as required in the individual's file maintained by the case manager. **At times case managers get a response from client's respective DSS worker indicating that they will not update the 122 (now the 225 form) because nothing has changed in the client's patient pay amount...thus most workers will write a date of ex: 1/01/2010-ongoing. This is a conflict with the regulations but the case manager does not have authority to force this agency to produce what is required. In this case, an auditor may ask for a payback amount if the service*

provider/case manager does not have this updated in the file. How is a case manager protected from this if this department will not revise the form from payback?

Point #4:

Audits need to administer measurable tools that have accountability for paperwork requirements (quantitative) as well as interviewing individuals/families for service satisfaction (qualitative). Ensuring that a service provider meets all requirements and are doing their diligence to meet all standards of assignments is important for documentation purposes and accountability.....but it's equally important to interview the individual as well as their family/guardian to evaluate the quality of services that are being rendered by the provider...ensuring that the focus is not just on administrative (paper trail) but on the individuals we serve...maintaining the person centered focus (reviewing qualitative supportive documentation).

Evaluations of service providers should also not be rendered once a year by a DMAS representative who marks the scores for the individuals/families...by doing this, the evaluations can be skewed. This evaluation tool, **which is important to determine quality of services, s**hould be mailed to the families/individuals with self-addressed envelopes to protect all confidentiality. Providers can produce what is needed in documentation, but there needs to be more monitoring and auditors need to pay more attention to the quality of services that are being rendered for the person who is currently being served.

Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

VACSB Comments Regarding the DMAS Audit Methodology for Home and Community-Based Services

On behalf of the VACSB, our forty member Community Services Boards and Behavioral Health Authority, and our designated VACSB representatives to the Audit Methodology Review Workgroup, thank you for the opportunity to provide our feedback to the report and the process instituted by DMAS to address this important issue.

Many of the issues regarding clarity and specificity of audit materials, dates of services to be audited, training of contract auditors regarding the services, and the policy approach to those services have been addressed in a number of other settings.

The items below are issues that we feel are important to continue to consider, address, and resolve for the benefit of DMAS, Medicaid recipients, providers, and the Commonwealth:

- As service areas for audit are determined, the VACSB strongly supports the development of an audit protocol that includes providers so that many of the avoidable issues auditors and providers face during an audit can be addressed beforehand. Through the development of an audit protocol, collectively we can hope to avoid preliminary findings for large paybacks only to find, through the appeals processes, that the payback is very minimal. This is costly to DMAS, to providers, and ultimately, to consumers of services.
- Part of any protocol and audit methodology must include provisions to allow for the use of a provider's electronic health record system. Auditors should ascertain in advance if a provider uses an electronic system for the health record. If so, auditors should be able to collect secure information and audit records using the electronic technology that constitutes a major investment for many providers.
- The VACSB believes firmly that the issue of "substantial compliance" should be explored more deeply and we applaud DMAS for wanting to continue the discussion. Even the use of weighting certain provisions of an audit could help address this issue. For items such as lack of or incomplete treatment plan, provision of service by an unqualified staff person, provision of services beyond what the treatment plan indicates without just cause: all of these are errors that are serious and should not be

considered in the same light as the lack of a credential with a signature when that credential is readily available in another document or in the health record. Since the Report indicates that there are other states using "substantial compliance', Virginia could benefit from further exploration of its use in appropriate audit areas.

- The VACSB supports the DMAS decision to base retractions upon "units" of service rather than "claims".

- As well, the VACSB supports the consideration of corrective action plans and compliance programs implemented by the provider through the settlement process.

- As policy direction steers services to person-centered approaches and demands recipient participation in the development of treatment plans, audits should be focused on how those policy approaches are implemented and work for the benefit of Medicaid recipients.

- The VACSB will support any effort to increase and improve training of the field and technical assistance to providers.

Thank you for allowing us to participate in this process and comment upon the Report. We appreciate the time and efforts of DMAS, the Workgroup and particularly, the VACSB representatives to the effort:
Beth Ludeman-Hopkins, Central Virginia CSB
Dee Keenan, Virginia Beach Department of Human Services
Jane Lewis, Region Ten CSB.

The VACSB stands ready to assist in future considerations of these issues.

VADHSA

Virginia Adult Day Health Services Association

"Your Partner in Caregiving."

October 12, 2011

Comments on the Draft Report for Item #297AAAA – Audit Methodology Report

Thank you for the opportunity to comment and for your attention to the concerns of the provider/stakeholders. The meetings were comprehensive and well constructed and clearly required additional time on the part of the DMAS staff. VADHSA appreciates the recognition of the providers' points and concerns and the thoroughness of the report. We do feel, however that critical issues were not resolved.

Sampling Methodology

- The methods used to select providers for audit create an unfair and unrealistic bias that will result in only the larger and more experienced providers being chosen. Smaller and/or newer providers will be excluded. Can the algorithm used for data selection be changed to include the entire provider community? We also would like to see a broader geographic representation.

- We applaud the willingness of DMAS to consider a shorter period for audit. The sample size in both periods of review and number of claims affects the business practices, as well as the time and cost structure to the providers. The audit process places an unreasonable burden on providers. Representatives of the provider community could provide invaluable and realistic insight as the audit methodology is finalized. Providers recognize the need for audits, but our concerns focus around the reasonableness and the overall impact on our business.

- We are opposed to random sampling and extrapolation as this does not meet the reasonableness test.

- Please consider sampling smaller agencies, and targeted non-random samples.

Error Codes

- The use of error codes was not addressed in the report but, several providers had major concerns. The auditor used multiple claims for one client in the same service period which resulted in duplication of overpayment dollars. The spreadsheets were very difficult to process and interpret. In one instance, a provider reported that the hearing officer in the formal appeal stated in his report that the data was so hard to decipher that even he could not determine the exact amount of overpayment that was due to DMAS. Because of the duplication of claims (i.e. multiple error codes for one client, for one service period), the report reflected a payback amount higher than the amounts actually paid by DMAS.

- We recommend that one error code be assigned per claim.

Substantial Compliance

- The major issue that needs to be discussed further is what constitutes a material breach of contract for providers as stated in the Provider Agreement. The manual states:

  "Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims." "Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and retraction of payment may be necessary." The use of the word **MAY** in both the manual and in the regulation gives DMAS discretion in making retractions.

- The regulation 12VAC30-120-930 calls for DMAS to conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's non–compliance with DMAS policies and procedures may result in retraction of Medicaid payment or termination of the provider agreement, or both. In addition, the Court of Appeals has issued an opinion that :

  "Under settled principles of contract law, appellant would be entitled to payment if its non-compliance did not amount to a material breach of the agreement".

- Providers are aware that DMAS has a defined obligation to meet both federal and state law and regulations; however, we respectfully request the DMAS provide some direction on where the state or federal law mandates full retractions.

- Please consider the suggestion that corrective action plans and compliance programs provided by providers during the settlement process would support compliance. Only a **material** and **substantial** lack of compliance should result in a retraction. It appears that DMAS can deem errors "non- material "when errors are not egregious and do not jeopardize the health and safety of consumers.

- Many of the audits did not uncover fraud, but reflected administrative or clerical issues. Could a different level of auditing be done based on the lack of evidence of fraud?

- We are pleased that this report confirms that retractions no longer will be based on bundled claims submission but on specific units of service. Some providers have not had this experience and are being assessed overpayment charges for entire weeks, months, or quarters. I would be glad to provide examples if requested.

AUDIT PROCESS

- In the beginning of the state's audit cycle, providers reported that the audit firm was not open to meeting with the providers to discuss issues, to answer questions, to provide additional material or to have an exit conference. We are appreciative that this is no longer the case. We encourage DMAS to continue to work with the contracted audit firms to ensure efficiency and accuracy.

- We also encourage DMAS to require that the audit firms have health care professionals and experts in intellectual disabilities and mental health to advise the auditors. The audits using this level of expertise reported greater accuracy, fewer errors, and more meaningful and open communication.

MISCELLENOUS

- The manual (guidance document) for providers and auditors needs to be updated. The regulations lack clarity and lead to multiple interpretations. Policies or regulations have changed 11 times in several years creating difficulty and confusion for all. We would like to have consistent and timely communication of any and all changes in order to remain compliant.

- Additional training on the regulations would be helpful and much appreciated in our mutual goal of quality delivery of service.

- The policy changes that are made need to be communicated to providers. Currently, DMAS puts the changes in the Appropriations Act /State Budget which makes it very difficult for providers to be compliant when they do not know what is expected. Please consider some method of "red flagging" of changes.

Thank you for consideration of these comments and for your willingness to work collaboratively with providers on how we can all improve the mutual outcome of the highest quality of care to the most vulnerable.

Lynne K. Seward,
VIRGINIA Adult Day Health Care Services Association

VIRGINIA ASSOCIATION FOR
HOME CARE AND HOSPICE
Advocacy. Education. Guidance.

Home Health
Hospice
Private Duty
Medicaid Personal Care
Medicaid Skilled Home Health
Infusion Therapy
Companion Services
Durable Medical Equipment
Pharmacy
Case Management
Consultants

October 12, 2011

Cheryl Roberts, Deputy Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

RE: Utilization and Review Audits of Community Based Care Providers

Dear Cheryl:

Thank you for the opportunity to review the draft "Evaluation of Effectiveness and Appropriateness of Review Methodology for Home and Community Based Services". We find the report to be a representation of the meetings held between August 21st and September 26th.

Given the facts outlined in this report, it would appear that the audits are intended to be a punitive tool to retract payments from the provider community. The utilization and review audit process imposed on home and community based providers is flawed and punitive. The punitive nature of the process is evident through a number of factors including: inconsistent audits, the use of data mining, unrealistic compliance requirements, and full claim retractions.

Sampling Techniques
The use of data mining to select a sample is a technique that draws a conclusion about something beyond the range of the data submitted that will result in reoccurrence of audits based on the number of claims submitted. Thus, the more claims submitted the larger the potential retraction and the more likely to be audited. We suggested that a random sampling be used which will be free of classification errors and selection bias. DMAS in the report inaccurately implies that Generally Accepted Accounting Principles do not recognize random sampling. In fact,

> "SAS No. 39 defines audit sampling as the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions for the purpose of evaluating some characteristic of the balance or class (AU 350.01)."

8001 Franklin Farms Drive, Suite 110, Richmond, VA 23229
(804) 285-8636 | FAX (804) 288-3303 « email vahc@vahc.org | www.vahc.org

We are unable to identify a regulation or law that requires DMAS to adhere to a specific sampling methodology and none is noted in the report. As noted in the draft Joint Legislative Audit and Review Commission report "*Mitigating the Risk of Improper Payments in the Virginia Medicaid Program*" DMAS does use a random sampling technique for selected program integrity audits. The current methodology is bias in that large providers are the subject of the majority of utilization and review audits. Furthermore, we also are concerned with the fact that consumer directed services have not been subject to any utilization and review audits.

Retractions and Substantial Compliance
The report notes that the EDCD provider manual states:

> "Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims . . . Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and retraction of payment **may** be necessary."

In fact, both the manual and regulation give DMAS discretion in determining what is subject to a retraction, using the word "**may**". Neither law nor regulation specifies what is considered verification.

> 12VAC30-120-930:
>
> 17. In addition to compliance with the general conditions and requirements, adhere to the conditions of participation outlined in the individual provider's participation agreements and in the applicable DMAS provider manual. DMAS shall conduct ongoing monitoring of compliance with provider's participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures **may** result in a retraction of Medicaid payment or termination of the provider agreement, or both; and . . . .

Recent decisions of the Court of Appeals also indicate that,

> "under settled principles of contract law, appellant would be entitled to payment if its noncompliance did not amount to a material breach of the agreement." Therefore, only a "material" lack of compliance with DMAS' provider agreement is sufficient to make a retraction. Given this, DMAS can deem errors "non-material" and choose not to retract.

The report fails to address industry concerns regarding a definition of substantial compliance and DMAS policy that allows for flexibility.

Evaluation of Effectiveness and Appropriateness
DMAS review methods and findings are inaccurate. In fact, when asked through the Freedom of Information Act to provide evidence that the initial retractions were upheld through the administrative process and the courts, DMAS responded as follows:

> "Neither the Appeals nor the Fiscal Division captures the "receivable" information in way that would be easily obtainable to produce a response. . . . Once a Final Agency Decision is issued, the Appeals Division turns the case over to Fiscal and the Office of the Attorney General (OAG). The Appeals Division does not track and has no data on the final collected amounts. The Fiscal Division does not capture the information by audit type or by contractor."

Given the lack of final resolution, we question how DMAS can consider this report an accurate evaluation of effectiveness and appropriateness of the utilization and review methodology for home and community based programs. We are also seriously concerned with DMAS's ability to appropriately monitor a contract that does not evaluate original error rates compared to actual (settled/final) error rates.

Survey Tool Limitations
The survey tool utilized by DMAS to collect information from other states is of limited use. The tool itself contains generalized questions with no distinction between a multitudes of audits conducted in accordance with CMS requirements. Not one question on the survey specifically addresses utilization and review audits.

DMAS has been presented Connecticut Public Act No. 10-116 which specifically addresses how and what constitutes an overpayment or underpayment to a provider.

Double Jeopardy
The report inaccurately states that providers are eliminated from the pool of utilization and review audits if they have been involved in a QMR. In fact, providers have had complementary QMR audit indicating quality of care and just days later have a utilization and review audit with initial retractions over $120,000.

Retractions
The report inaccurately states that DMAS only retracts for the number of units found to be out of compliance. We have had a number of conversations regarding units of services and claims. A unit is individual or discrete part of a claim which can be divided, especially for analysis For example, a unit would be the preauthorized number of

personal care hours for a given day. As a practical aspect and with direction from DMAS, providers have been encouraged to submit CMS-1500 claims as a combination of units for an extended period of time. This "claim" is also referred to as an invoice in DMAS manuals. If there is an error in a claim, whether material or not, the entire claim is retracted.

There is no federal requirement that addresses what documentation is needed to support a claim for payment. That is left to the states to determine. That means that the state has the authority to determine the impact of a defect in documentation. In fact, despite several requests DMAS has failed to point to a state or federal regulation that requires total retraction or prohibits a substantial compliance standard.

According to the draft Joint Legislative Audit and Review Commission report "*Mitigating the Risk of Improper Payments in the Virginia Medicaid Program,*"

> Federal regulations require DMAS to investigate a provider . . . until one of the three outcomes is achieved:
> - Investigation closed because of insufficient evidence.
> - Appropriate legal action is initiated.
> - The matter is resolved . . . This resolution may involve a warning letter to the provider, suspending or termination the provider, recovering improper payments, or imposing other sanctions.

Conclusion
We continue to disagree with DMAS conclusions that the majority of compliance polices and standards currently used by the agency are effective in identifying non-compliance given the lack of evaluation of initial retractions and final settlement. We strongly believe that a audit methodology that contains components found in the Appropriations Act which was passed by the 2011 House of Delegates creates a fair process for both providers and DMAS.

Thank you again for the opportunity to provide comments to the draft report. As always, we look forward to working with DMAS to improve the integrity and quality of care delivered to Virginia's disabled and elderly.

Sincerely,

Marcia A. Tetterton, MSG, CAE
Executive Director

Virginia Network of Private Providers, Inc.
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Richmond, Virginia 23236
vnpp@earthlink.net
www.vnppinc.org

An association for persons or organizations with an interest in or that provide support for persons who have mental illness, developmental delay or substance use disorder, and who are licensed by or funded by the Department of Behavioral Health and Developmental Services.

October 11, 2011

Thank you for the opportunity to comment and for the time and attention which the DMAS staff gave to the several meeting with the stakeholders involved. The report captures both the process used to conduct this review and the background and the basis/requirements for audits in federal and state regulations and code; the report also describes the processes used by DMAS and/or their contract auditors to prepare for and to conduct the audits.

Sampling Methodology:

- VNPP has had concerns that the methods used to select providers for audit created a bias toward the larger more experienced providers and excluded the newer, smaller, less experienced providers who may or may not have the expertise and experience to be providing a quality service. It is our understanding that the QMR Reviews do sample more consistently from the latter group and that significant findings during a QMR Review may lead to a more formal audit. That satisfies our concern.

- Sample size (both in number of claims and period of review) is an issue of volume, cost and effort on the part of the provider. For example, the cost and time required to pull and copy a record for a 24 hour/day service for a month is far greater than to do the same for a record for a service offered a few hours per day a few days a week. We suggested that a provider(s) be involved in the final review of the audit program/protocol as it is developed; such involvement would minimize the possibility of unreasonable demands which do not further the overall objectives of the audit.

- VNPP did not offer comments in support of random sampling and does not, if DMAS chooses to explore this further, support using random sampling as a reason to justify extrapolation.

Substantial Compliance:

- VNPP continues to feel strongly that we need to continue the discussion to come to agreement on what constitutes a material breach of the contract a provider has with the Medicaid Agency by virtue of their Provider Agreement. We are supportive of the possibility outlined in the report that "consideration of corrective action plans and compliance programs implemented by the provider may be appropriate during the settlement process."

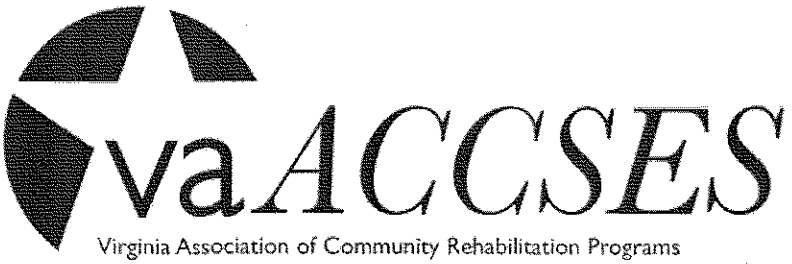
- VNPP supports the statement in the conclusion that this is an issue which requires more thorough consideration.

- VNPP is also pleased that this report confirms retractions based upon "units" of service and not upon "claims;" this is a significant statement of policy which we support.

Again, thank you for the opportunity to comment. We look forward to being able to continue our dialog as you further explore the issues of "substantial compliance" and the implementation of "process improvements."

Jennifer B. Fidura

cc Board of Directors



October 11, 2011

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

RE: Draft Medicaid Audit Methodology Report

We appreciate the opportunity to submit comment on the draft Medicaid audit methodology report for home and community-based services. We also greatly appreciated the opportunity to actively participate on the stakeholder workgroup which met three times during August and September 2011.

The report does a good job of providing an overview of the report's legislative mandate, the stakeholder consult process, the national state survey conducted, the DMAS audit process, review methods and findings, as well as DMAS's legal authority and provider requirements for Medicaid Reimbursement.

However, the draft report provides only a few pages of stakeholder concerns and brief discussion and response by DMAS. It may not reflect a complete picture of ID/DD and Day Support Waiver provider concerns voiced during the stakeholder workgroup sessions, public testimony and/or written comment.

Selection of ID/DD Providers for Audits and Sampling Methodology

The risk indicators and the ranking of these risk factors used by the DMAS data mining software to select providers to audit may be outdated and may need to be updated before the next round of audits, as well as periodically updated going forward. Our overall concerns regarding this issue include:

1) A risk factor acknowledged and utilized by DMAS includes a high utilization of more intensive supports which disproportionately targets providers that support individuals with high intensity needs. This risk factor does not reflect the ever-changing and true characteristics of individuals currently being served in the community by providers. This identified risk factor seems to be discriminatory in nature and appears to target Virginians with severe disabilities served through community-based waivers. For example:

Virginia Association of Community Rehabilitation Programs, 7420 Fullerton Rd, Suite 110, Springfield, VA 22153
Toll Free (877) 822-2777 * Local (571) 339-1305 * Fax (703) 569-3932
E-mail:ktefelski@vaaccses.org * Website: www.vaaccses.org

a) For many years now, only individuals transitioning from institutions or who are on the Waiver "Urgent List" have received new slots in the community. These individuals, by nature and by code definition, would need more intensive supports. HCBS Waivers are currently focused on providing more person-centered services in the community.

b) The small number of providers that provide community-based day support in smaller client to staff ratios utilize high-intensity services almost exclusively to provide these specialized services. The entire waiver system wants to move in this direction. Thus, the DMAS identified risk factor for audits of high utilization of high intensity supports in is direct conflict with the current waiver system's overall commitment and priority focus on individualized supports provided in the community.

c) The mere targeting of utilization of high intensity supports questions the current justification and approval process of prior authorization that is needed to provide high intensity supports to waiver recipients. If there is a concern or question about the authorization and utilization of high intensity supports, is should be publicly discussed and properly amended - but not through an after-the-fact audit.

2) A risk indicator identified and utilized by DMAS includes high volume providers. This risk factor overwhelming discriminates against providers that have the resources and corporate structure to provide waiver services to a larger number of individuals served by the HCBS waiver. These providers are repeatedly audited. Unless there is past involvement and verification of fraud or a historic pattern of abuse, a large volume of services provided should not be a risk factor. The only conclusion for this risk factor is that DMAS utilizes this risk to "maximize efficiency". This does not meet the definition of a "risk indicator" but an "economy of scale" internal operational strategy.

3) The case sample utilized by DMAS as well as the use of a 15-month time period is unreasonable. We appreciate DMAS's consideration of shortening the audit time period to 12-months. This is more realistic and. A 15-month time period may capture three fiscal years which is an overwhelming hardship for providers. However, the use of a 25-35% of total number of claims for an individual provider is unreasonable. Research industry standards are customarily 7-12% to get a statistically correct sample. A smaller sample size would not necessarily jeopardize the integrity of the audit and purpose of the review. It would still be able to verify that services were delivered appropriately and to ensure that public funds are used as intended.

4) We do not support the concept of random sampling if it is used in conjunction with extrapolating error rates to all claims submitted by a provider during the review period.

The issue of "Substantial Compliance" remains unresolved.

Nothing in State of Federal law requires DMAS to apply an inflexible and stringent approach to Medicaid audits. Although states are required by Federal statute to conduct post-payment audits in order to "ensure the proper and efficient payment of claims and management of the program", Federal law does not prescribe specific methodologies that states must use to conduct these audits. Each state can establish its own rules and audit procedures. CMS regulations simply require states to establish methods for identifying suspected fraud or abuse. The details of Virginia's compliance standards for Medicaid providers are directly within DMAS's purview to determine.

1) DMAS must establish an audit methodology that requires auditors to consider the full body of evidence presented by the provider in order to determine whether the provider is "substantially compliant" with documentation requirements. Pristine documentation is virtually impossible. Human error is inevitable. A regimented approach to provider audits that "nitpicks" and uses seemingly "gotcha" techniques is unnecessary. These techniques undermine the goals of the Medicaid program by reducing payments to providers and thereby providing less money for providers to hire quality staff and provide high quality of care standards. We agree with the following definition of substantial compliance:
    a. Medically appropriate and approved, covered services were in fact furnished to an eligible beneficiary in accordance with Medicaid quality of care standards;
    b. The provider acted in good faith without willful disregard of Medicaid requirements, and
    c. Any identified deficiencies caused no more than minimal risk to the beneficiary's health and safety.

    In order for "substantial compliance" to work, it is imperative that a provider be given the opportunity during the audit process to furnish alternative or additional material/documentation that can supply missing information and otherwise support the delivery of the covered services in question.

Any retraction should be based on the disallowed unit versus a total "claim".

Retractions must be done only for the portion of the claim which was:
- Not an allowable service/activity
- Not properly documented, or
- Was provided by an unqualified individual

A proactive training and self-auditing approach as suggested during the stakeholder workgroup discussions is not adequately addressed by the draft report.

Simple proactive efforts would vastly improve the integrity of the process for providers. Unintentional errors and omissions are the greatest cause for retractions. Providing the tools necessary to clearly understand the audit process and specific requirements to

providers would greatly improve the audit experience and would reduce unintended errors. This may include but is not limited to:

1) Simple efforts such as targeted training to the ID/DD provider community by DMAS staff (as previously provided in partnership with vaACCSES in 2001-2002), and a proposed timeline in the report would be most helpful.
2) Making available the QMR as well as the auditor and/or auditor program check-list would be extremely beneficial.
3) CARF accreditation was not mentioned during workgroup discussions to suggest a "get out of jail free card". CARF accreditation was mentioned as an example of a process that works. The CARF process, standards and tools are readily available to providers via a manual, training and technical assistance. There are ample resources to empower a provider to know what to do and what to expect from an onsite CARF review/audit.

Again, thank you for the opportunity for vaACCSES to participate on the Stakeholder Workgroup as well as submit further comments to the draft DMAS Audit Methodology Report. We look forward to working with you and the General Assembly on the implementation of the report's recommendations. Please do not hesitate to contact me if you have questions about the comments that we have expressed. I can be reached at 703-200-7660 (cell) or 804-368-7555.

Respectfully,

Karen Tefelski
Executive Director

BUILDING COMMUNITIES OF FAITH AND LIFELONG HOMES
WITH PEOPLE WHO HAVE INTELLECTUAL DISABILITIES

October 12, 2011

Department of Medical Assistance Services
ATTN: Review of Medicaid Audit Methodology, Item 297(AAAAA)
600 East Broad Street
Richmond, Virginia 23219

Re: Comments on Draft Audit Methodology Report; "Substantial Compliance"

Dear Sir or Madam:

Thank you for the opportunity to comment on the Draft Audit Methodology Report ("Draft Report") prepared by DMAS pursuant to Item 297(AAAAA) of the 2011 Appropriations Act, and released under cover letter dated October 6, 2011.

We reiterate our comments included in our letter of September 26, 2011, a copy of which is attached. The full version of this letter was mistakenly omitted from Attachment V to the Draft Report, entitled "Written Communications from Stakeholders." (Only the first page of our letter appears at page 33 of the Draft Report.) We ask that DMAS include the complete version of our September 26, 2011 comment letter in the Final Report.

We disagree with DMAS's characterization of "substantial compliance" as a "lower standard." *See* Draft Report, at 16. Rather, the "substantial compliance" standard we propose would simply require auditors to take a rational approach by considering the entirety of the evidence furnished by providers in determining whether covered services were furnished. *See* L'Arche's Comment Letter (Sept. 26, 2011), at 2-6, attached. This is consistent with the case-by-case review of claims preferred by DMAS. Under our proposal, an overpayment should not be assessed when it is clear, from the entire record, that medically appropriate, covered services were furnished to eligible beneficiaries in accordance with Medicaid's quality of care standards, and there is no evidence of fraud or abuse. As DMAS notes, "DMAS has a duty to ensure that individuals receive services that are safe and appropriate to their needs." *See* Draft Report, at 16. **We fervently believe that a "substantial compliance" standard can be implemented without jeopardizing patient safety, quality of care, or program integrity. Indeed, the rational approach we suggest would further enable DMAS to ensure that services are available to covered individuals by reducing**

unnecessary appeals from pointless audit denials based on clerical errors and regulatory nits that do not undermine the overall evidence that appropriate services were provided.

We agree with DMAS that the "substantial compliance" standard warrants further examination, though we do not understand what "practical and legal issues" would prevent auditers from reasonably considering providers' records as a whole in evaluating compliance with Medicaid rules and standards. The standard we propose promotes, and does not undermine, patient safety, quality of care, and program integrity. *See* Draft Report, at 17. We urge DMAS to continue investigating possibilities for audit methodology reform along these lines, and to follow up with those states that indicated on their survey responses that they employ a substantial compliance standard. *See* Draft Report, at 14 n.4.

Please feel free to contact Steve Keener, at (202) 232-8477, with any questions you may have.

Sincerely,

John Cook, Executive Director
Steve Keener, COO and General Counsel
L'Arche Greater Washington, D.C.

Enclosure

WILLIAMS MULLEN

Direct Dial: 804.420.6934
mdonlan@williamsmullen.com

October 13, 2011

Ms. Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 13th Floor
Richmond, Virginia 23219

Re: Comments on Draft Audit Methodology Report

Dear Ms. Jones:

The Virginia Association of Personal Care Providers ("VAPCP") does not find the Draft Audit Methodology Report ("Draft Report") of the Department of Medical Assistance Services (the "Department") to have satisfactorily addressed its concerns about the audit process and the retraction of payments based on adverse audit findings which do not warrant full payment retraction given the errors allegedly found. The VAPCP also wishes to note that the Draft Report was provided to it just before a three-day holiday weekend and the response time was effectively limited to two business days which it finds to be insufficient for a serious matter that has been under consideration for many months.

In any event, a basic failing of the Draft Report is that it fails to address the fact that the audits of personal care providers have routinely shown that Medicaid recipients received the assistance they needed with their activities of daily living ("ADLs"), the core service of personal care providers, and that the hours of services provided were equal to the hours billed. Rather, the audit process and the retractions based thereon are for documentation errors that do not warrant retraction of payment and certainly not the full retraction of payment. The VAPCP finds this audit approach to be unreasonable and wishes to give a few examples of unreasonable payment retractions based upon common documentation error findings at audit.

As the Draft Report notes, the most frequently alleged error after audit was that an Aide Record did not contain "required weekly or appropriate comments." In fact, in almost all cases, aides did write a weekly comment, but the audit claim was that it was not sufficient or that the comments were repetitive from week to week. Where no comment was made, generally there were multiple aides providing services that week, and only one aide did not write a comment. What DMAS' auditors generally challenged was that the comments would be simplistic, stating

the recipient "had a good week" or "no change, no complaint" or ""was doing fine." While these Aides' Records reflected that all of the assistance with ADLs was provided, an entire week's worth of payment was retracted because the comment was deemed insufficient by an auditor. Additionally, if weekly comments appeared repetitive, entire weeks of reimbursement were retracted without regard to the fact that the recipient did not change appreciably from one week to the next. Recent appeals have overturned this based on hearing officers' finding such comments were sufficient because nothing "significant" had occurred to be reported. However the Department's and some hearing officer rulings have also found against providers. Clearly, this has become a subjective determination with uncertain standards of review and providers need more guidance, at the least.

Unfortunately, rather than give more guidance on this issue, in July 2011, a revision was made to the EDCD Waiver Services Manual (the "Manual") and the Department deleted the word "significant" when describing aide comments in the Manual. The VAPCP has asked for was a revision to the Aide Record form so that aides would be asked about changes in a recipient's condition in the areas in which DMAS believes a comment is needed. We believe this is an important change that should be made because aides are not licensed healthcare providers and are merely assisting recipients with their ADL needs as identified by licensed healthcare providers. Asking them as laypersons to form opinions and give observations on a recipient's physical and emotional condition is at best questionable. Asking the aides to comment on daily activities and responses to services seems reasonable, but it is actually difficult to do because these recipients have long term disabilities and neither their daily activity needs nor response to services change much. Thus, on all four issues, a comment that the recipient "is doing fine" seems fully responsive, yet it is consistently challenged.

The Department seems to recognize that the condition of this type of recipient changes little in the Manual. It does so when it allows our nurses to review a recipient's Plan of Care annually and on review to continue that plan for another year merely by re-dating and re-signing it with a notation that no changes are necessary. Thus, asking aides to comment on a weekly basis when recipients are not experiencing changes or having any problem makes it difficult for any aide to write something more meaningful other than affirming in lay terms that the recipient's condition is unchanged, i.e. "had a good week." Accordingly, we strongly suggest that the Aide Record be revised as the VAPCP suggested to the Department. See Draft Report, Attachment V, Page 34.

The second most frequent error involved "dates and/or hours billed not matching the Aide Record." Again, a concrete example is helpful. Auditors retracted payment when an

invoice for 30 hours in a specific week showed the beginning date and the ending date as the same date while the underlying Aide Record, in fact, covered the full week. The error made by the billing clerk was to use the same date for the beginning and ending day of the week. The audit result was to retract payment for all days but the one day on the invoice even though the other hours were not billed on any other invoice. This is clearly the type of error that is not material and should not be the basis for any payment retraction.

Another example is where the week of service covers two months, but the billing clerk billed the entire week either in the month ending that week or in the month beginning that week. As DMAS' policy requires that services in a month be billed only in that month, the auditors retract payment even though the days were only billed once. Again, this is not a reasonable basis for retraction of payment. At most, the auditors should simply re-classify the hours to the correct months to be sure that the allowed monthly hours were not exceeded and if exceeded then retract any excess payment.

The next most common audit finding was that a preadmission document was not present in the record. In these cases, there is no question that the recipient required the services rendered and often had been receiving services for many years. Moreover, the local Departments of Social Services, which should also have a copy of the record, purge their records because they had different documentation retention standards. In such a case, retraction should not be made rather the provider should be allowed to prove that the recipient needed the services or in effect recreate the lost documentation. Moreover, the Department's practices could be altered to avoid this issue altogether. All of the documents for preauthorization could be sent to the Department's preauthorization contractor and maintained there. If a provider's like documentation has been misplaced, then both the provider and the Department would have a source from which the documentation could be recovered. Retractions of payment for up to 15 months are simply unwarranted.

When the VAPCP speaks about substantial compliance, it means substantial compliance both materially and quantitatively, that is, the error was material and it was so common as to support an adverse consequence to the provider. We believe that the Department's concern with a substantial compliance standard is that in almost all cases providers are in substantial compliance; thus, the cost of the audits would not be recovered and the Department necessarily wants to recover more than the cost of the audits. This is a classic perverse incentive to use audit standards that are harsh and retract payment for services that were needed and were rendered.

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In this regard, the auditors also review records without regard to a recipient's record taken as a whole. As noted above, the Department seeks to retract payment where a document required before commencement of services is no longer in the recipient's record, even where all of the current medical and nursing information plainly establishes that the recipient was being provided appropriate services needed to avoid care in a nursing home and where those services had been authorized for many years. Such an error is not material where the recipient plainly needs the services and it appears that the document was simply lost or misplaced and now cannot be recovered for the originating agency because they did not retain it in their records. A 100% payment retraction is simply not warranted and becomes a penalty for what is a simple clerical error.

Similarly, if the review date for a Plan of Care is missed, yet the month or bi-monthly nursing reports show that there was no change in the recipient's condition and no change in the Plan of Care was made when the oversight was discovered, retracting payment for up to 12 months because a Plan of Care review date was missed is a huge penalty. Again, loss of all payment for such an oversight is simply not warranted in our view. The Department and the recipient received the services needed and the documentation error caused no damage to the Department or the recipient. Thus, the VAPCP believes that the Department should make no retraction in such circumstances.

Alternatively, the Department could establish a percentage scale for retractions based on ranking errors by their severity and frequency. While the Department has on occasion said it does not have such authority, I am not aware of and I can find no legal prohibition on the Department establishing such a rule. The states are given great flexibility in setting their program standards and regulations by the federal government in this regard. This is not a matter of prohibition, but willingness to exercise reasonable discretion.

Lastly, the VAPCP is opposed to an audit methodology which is based upon random sampling and extrapolation. The problem with the current audit process is not its randomness, but that it results in payment retractions for services that were actually rendered and needed because there were errors in documentation. The issue is not whether there was an error in documentation, other than perhaps for weekly comments which are subjective retractions, but that the error does not justify a payment retraction or certainly does not justify a 100% payment retraction. Moreover, the length of the audit period is simply too long and too distant in the past. Consider that the audits in 2011 generally covered 2008 and the beginning of 2009. If the audits in 2012 cover the end of 2009 to 2010, then providers will not have had an opportunity to correct any systemic documentation issue, like challenged aide comments, identified in the 2011 audits.

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The VAPCP suggests that the 2012 round of audits be limited to a period of nine months beginning with claims made no earlier than nine months prior to the commencement of the audit, i.e. if an audit commences April 1, 2012 then the first claim would be from July 1, 2011. This will allow providers to have learned from any errors in prior audits because, although the regulations have not changed, the Department's interpretations of them in recent audits have.

The VAPCP believes the Department has misunderstood the problems that the VAPCP has raised with the current audit process and audit standards. What the VAPCP seeks is fairness in the audit process and payment retractions that are sufficient to encourage better documentation, but not so onerous that they are better described as penalties. The VAPCP wants to work with the Department, but so far the Department seems more intent on retracting payment for services that were provided and needed based on simple documentation mistakes rather than addressing how unnecessary and excessive payment retractions can be avoided or lessened for a group of providers that aid the Commonwealth by assisting families in keeping their relatives out of more expensive nursing home care.

Sincerely,

Virginia Association of Personal Care Providers

By: _____
Martin A. Donlan, Jr., Counsel

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cc: Virginia Association of Personal Care Providers Board (via email)