COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

December 7, 2012

MEMORANDUM

TO: The Honorable Walter A. Stosch
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report of the Activities of the DMAS Advisory Group on Audit Methodology for Home- and Community-Based Services

Item 307 YYY of the 2012 Appropriations Act directs the Department of Medical Assistance Services (DMAS) to establish an advisory group of representatives of providers of home- and community-based care services to continue improvements in the audit process and procedures for home- and community-based utilization and review audits. In addition, Item 307 YYY requires a report by December 1, 2012 on any revisions to the methodology for home- and community-based utilization and review audits, including progress made in addressing provider concerns and solutions to improve the process for providers while ensuring program integrity.

DMAS worked with providers to establish this advisory group and held two meetings during summer 2012 to collaborate with providers and continue education as well as enhancements to the process. The following report gives an overview of changes DMAS and its contract auditors have made to the audit process as a result of provider concerns as well as an overview of issues discussed during the advisory group meetings.

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

CBJ/vpp

Enclosure

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

Report of the Activities of the DMAS Advisory Group on

Audit Methodology for Home- and Community-Based Services

Virginia Department of Medical Assistance Services

December 1, 2012

Table of Contents

Legislative Direction

This report responds to Item 307 YYY of the 2012 Appropriations Act (Attachment 1) which directs the Department of Medical Assistance Services (DMAS) to establish an advisory group of representatives of providers of home- and community-based care services to continue improvements in the audit process and procedures for utilization and review audits of these providers. In addition, Item 307 YYY requires a report by December 1, 2012, on any revisions to the methodology for home- and community-based utilization and review audits, including progress made in addressing provider concerns and solutions to improve the process for providers while ensuring program integrity. DMAS worked with providers to establish this advisory group and held two meetings during summer 2012. The following report gives an overview of changes DMAS and its contract auditors have made to the audit process as a result of provider concerns, as well as an overview of issues discussed during the advisory group meetings.

Background

The Medicaid program is a partnership between Federal and State governments; Federal regulation provides a framework for Medicaid program integrity activities, but each State is given wide latitude in developing their individual programs. DMAS programs have evolved over time to best accommodate the needs of the Virginia Medicaid program based on General Assembly actions as well as internal agency efforts. DMAS conducts several types of Medicaid integrity activities, including prior authorization of medical necessity, utilization reviews, financial review and verification, investigations of fraud and abuse, as well as quality reviews focused on patient health and safety. Each of these review types correspond to sections of the Code of Federal Regulations (CFR.) Utilization reviews and financial review and verification encompass the audit process which is the major subject of this report.

Home and Community Based Services

Home and Community Based Services are provided to individuals enrolled in Medicaid who meet criteria for admission to a hospital, nursing facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) but choose to receive services in a less restrictive and less costly community setting via 1915(c) waiver authority granted by the Centers for Medicare and Medicaid Services (CMS.) DMAS operates six Home and Community Based Service (HCBS) Waivers including the Technology Assisted, Individual and Family Developmental Disability Support (DD), Elderly or Disabled with Consumer Direction (EDCD), Intellectual Disabilities (ID), Day Support (DS), and Alzheimer's Assisted Living waivers. The ID and DS waivers are administered by the Department of Behavioral Health and Developmental Services (DBHDS). Waiver functional eligibility is established by screening teams that use a standardized assessment to determine if individuals meet the criteria for the alternative institutional level of care criteria, either hospital, NF or ICF/ID.

A variety of services are provided to HCBS waiver individuals, based on the care needs that they have, the family and community support available, and the services offered within 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 registered nurse, services facilitator or case manager assesses each individual and works with them to create a Plan of Care that outlines the service types and number of hours of care required to assure that care needs are met and that the individual can remain safely in the community.

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 services delivered under this model. The agency and the FEA are responsible for obtaining documentation of the background checks and CPS registry checks where appropriate.

Prior Authorization

DMAS requires prior authorization of medical necessity for a wide variety of services including waiver enrollments and home health services. DMAS employs a contractor to evaluate the medical necessity of a service based on information submitted by the servicing provider. In addition, DBHDS authorizes services provided under the ID Waiver. In authorizing HCBS, it is not the service itself that is authorized, but instead a determination is made of the maximum number of hours that will be allowed as medically necessary. By performing this practice before the service is delivered, DMAS can ensure that payment is only made for necessary services. In addition, providers receive greater clarity on the level of service DMAS deems appropriate.

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 meet CMS assurances and ensure the health, safety and welfare of individuals receiving HCBS. QMRs are federally mandated by 42 CFR § 441.302 and require that: 1) assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of services; 2) assurance that all providers 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 be terminated or not renewed by CMS.

Providers are selected for review based on statistical analysis, with some emphasis on providers who are new to the Medicaid system. DMAS conducts both onsite and desk reviews that include critical policies and healthcare practices pertaining to the individual, personnel and the agency. Areas reviewed include: screening documentation; continuity of care; staff qualifications; and the quality of delivered services. Reviews are unannounced and can result in

outcomes including: technical assistance and/or training; a Corrective Action Plan submitted to DMAS; and referral to the Provider Review Unit (PRU) for further review. QMR does not directly result in retractions, though subsequent Provider Review Unit audits may identify recoverable overpayments.

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, PHBV Partners (PHBV), formerly Clifton Gunderson. 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.

The DMAS provider manuals for HCBS providers set forth DMAS policy for the review of personal and respite care and reference 42 CFR §455 and 456 as the authority under which DMAS conducts reviews. Each 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.

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.

Establishment and Activities of 2011 HBCS Advisory Group

2011 Stakeholder Meetings

Item 297 AAAAA of the 2011 Appropriations Act directed DMAS to consult with representatives of providers of Home and Community Based Services concerning audits of such providers, evaluate the effectiveness and appropriateness of the audit methodology and report to the Governor and Chairmen of the House Appropriations Committee and Senate Finance Committee. As directed by the Act, DMAS held a series of collaborative stakeholder meetings during the summer and fall of 2011 to obtain input from HCBS providers on the DMAS audit methodology and published a report on November 1, 2011. This report: 1) described the stakeholder process; 2) described DMAS audit programs; 3) described HCBS services; 4) provided a summary of DMAS audit activities and recent audit results; 5) reported on the survey of state Medicaid audit practices with comparisons to DMAS practices; and 6) discussed stakeholder issues and provided recommendations.

The stakeholders identified five major areas in which they desired change: 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 these concerns and DMAS' responses are discussed in DMAS' report published November 1, 2011 entitled *Evaluation of Effectiveness and Appropriateness of Review Methodology for Home and Community Based Services.*

Results of Prior Year Stakeholder Meetings

DMAS Changes to HCBS Regulations

Pursuant to these meetings, DMAS staff from the Long Term Care Division have made or proposed several changes to HCBS regulations and policies. Regulatory changes have been submitted to the Governor for the Elderly or Disabled with Consumer Direction (EDCD) Waiver, the Technology Assisted (Tech) Waiver and the Intellectual Disability (ID) Waiver. These regulatory changes are still in the regulatory review process.

DMAS Changes to HCBS Forms

In addition to regulatory revisions, DMAS has updated, piloted and implemented changes to the DMAS 90 form, which is used to document personal care services. Based on input from providers at the 2011 stakeholder meetings, DMAS added "check boxes" to this form in order to streamline completion of the document.

Licensure of Home Health Care Agencies

DMAS has successfully implemented Senate Bill 265 of the 2010 General Assembly session, which required the licensure of Home Health Care Agencies by July 1, 2012. This process was piloted first with personal care providers who were renewing their Medicaid enrollment and then rolled out to all Home Health Care agencies in July 2012. This legislation, which had broad-based support, strengthens protections for individuals needing care provided by home health care agencies.

DMAS Changes to Audit Review Period

Pursuant to provider concerns expressed during stakeholder meetings held during 2011, DMAS also has taken efforts to adjust the methodology and conduct of financial and utilization review audits. First, DMAS reduced the claim period for the DMAS audit review from 15 months to 12 months. In addition, DMAS enhanced the subject matter experts (SMEs) process by formalizing the meetings which include training and clarification for auditors on DMAS long-term care programs, and review of all error codes.

DMAS Changes to Provider Selection Process

Representatives of the Virginia Association of Community Rehabilitation Programs (VaACCSES), among others, 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 should be included in reviews for both financial and safety reasons. Stakeholders also 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.

DMAS concurred with stakeholders that providers subject to review could be expanded to include all providers, regardless of size. DMAS notes that its provider selection process is not based on provider size exclusively, but rather patterns that indicate likelihood for improper billing. DMAS expressed a willingness to make efforts to subject all providers to review, regardless of size or claims volume characteristics, although samples may continue to be targeted rather than randomly selected. Lastly, 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.

Establishment and Activities of 2012 HCBS Advisory Group

Item 307 YYY of the 2012 Appropriations Act directed DMAS to establish an advisory group of HCBS providers to continue improvements in the audit process and procedures for HCBS utilization and review audits. As directed by the Act, DMAS established an advisory group including representatives from provider groups representing major providers of HCBS, DMAS Program Integrity and Long Term Care staff, as well as representatives of the Department of Behavioral Health and Developmental Services.

The first HCBS Advisory Group meeting occurred August 16, 2012, with DMAS staff providing an update of changes that have been made to HCBS audit process, forms and regulations. A general discussion followed with providers indicating a desire for DMAS training on best practices and clarification on the audit process and critical elements of the case file along with several other issues. DMAS audit staff then discussed the process used to identify which providers and claims to audit. In addition, DMAS contract auditor PHBV gave a presentation on the process and methodology they use when auditing HCBS providers.

At the end of this meeting, the group agreed upon six major topics for discussion at the next meeting which included: 1) length of the audit review period; 2) audit sample (medical records) size; 3) Aide record vs. plan of care; 4) partial retraction and substantial compliance; 5) audit review areas; and, 6) the definition of "objective written documentation" with regards to personal care/respite provided by family. In addition, the group requested that PHBV present a review of the most frequently used "error codes."

The second advisory group meeting occurred September 13, 2012. PHBV presented the most frequently used error codes and discussed these error codes with the group. The group then discussed each of the six areas identified. A list of meeting participants for each of these meetings is found in Attachment II. This report: 1) outlines changes made to the HCBS audit methodology pursuant to stakeholder meetings held under Item 297 AAAAA; 2) discusses information on DMAS staff and contractor audit activities and methodology presented to the HCBS provider advisory group convened pursuant to Item 307 YYY; and 3) provides a summary of issues discussed during HCBS Advisory Group meetings.

Provider Selection and Audit Process

During the August 2012 meeting of the HCBS Advisory Group, DMAS and PHBV each gave presentations outlining how providers and claims are selected for review and how audits are conducted. At the request of providers, PHBV gave a presentation at the September meeting on the most common types of errors. The content of those presentations is summarized in the following section.

DMAS Provider Review Unit Audit Process

The PRU Unit utilizes an annual audit plan to determine selection of provider types to review. This audit plan utilizes provider type risk assessments along with input from DMAS staff to determine the number of reviews it plans to conduct of each provider type during a given fiscal year. 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.

PHBV (formerly Clifton Gunderson) Audit Process

In addition to audits conducted by PRU staff, DMAS also contracts with PHBV to conduct additional audits of providers. The first step of the PHBV audit process involves running claims through a proprietary data mining software program that is customized for use with DMAS data. Examples of trends of interest include unusual increases or decreases in claims volume, gaps in the data, and length of service. Claims selection is conducted based on professional judgment for non-statistical samples. 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 by PHBV, they are reviewed by DMAS 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 those providers. After the final approved selection is made, PHBV 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, higher-level management review. An exit conference is conducted to explain the review findings and reporting process. Preliminary findings are submitted to providers who then have an opportunity to submit additional documentation to support their claims. 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.

Common Errors Found in Audits

During the September meeting, PHBV made a presentation (see Attachment III) which reviewed the most frequent error codes found during provider audits. Those broad areas were:

- Staffing requirements
- Requirements for admission documentation
- Requirements for documentation of services rendered
- Requirements of supervisory activities
- Services documented in accordance with plan of care
- Reconciliation of documented services to those billed and paid

In summary, PHBV indicated that the best practice is for providers to consult the Virginia Administrative Code (regulations) and DMAS Provider Policy Manuals to assure compliance.

Advisory Group Issue Discussion

During the September meeting, the group discussed six major issues identified during the August meeting. These issues included: 1) length of the audit review period; 2) audit sample (medical records) size; 3) Aide record vs. plan of care; 4) partial retraction and substantial compliance; 5) audit review areas; and, 6) the definition of "objective written documentation" with regards to personal care/respite provided by family. An overview of this discussion follows.

Items 1 & 2: Length of Review Period/Audit Sample Size

As mentioned earlier, DMAS, at the request of providers, had previously agreed to reduce the review period from fifteen to twelve months as a result of stakeholder meetings held last year. Some advisory group members indicated a desire for further reduction in the period of review to a six-month period. Representatives of vaACCSES and the Virginia Association of Personal Care Providers (VAPCP) suggested that a six-month audit period would reduce the amount of paperwork and labor required to pull a client's information.

DMAS staff stated that if auditors moved to a six month review period, the number of members/cases drawn for sample would not change; that is, the "reign of the sample" would still have to capture sufficient number of members/cases reviewed resulting in a compression of the review activity into a smaller period of time (from twelve to six months). Also, regarding the current twelve-month review period, the longer review period allows for auditors to observe how the provider has grown over time. For example, if errors found early in the twelve-month period are corrected as the record progresses in time, this would document provider growth and improved compliance. The consensus of providers was that the reduction of the audit time period from fifteen to twelve months was a positive change in audit methodology.

DMAS staff and contractor audits currently examine claims submitted one or two years prior to the year in which the audit is conducted. Providers indicated a desire that DMAS staff and contractor audits examine a more current review period so that the review would fall within the twelve-month billing cycle. Representatives of VAPCP as well as Virginia Adult Day Health Services Association (VADHSA) stated that this would be more reflective of current practice, and ideally would allow providers to resubmit their claims to correct errors identified during the audit.

DMAS Program Integrity staff noted that the purpose of utilization/financial review audits is to examine the validity of submitted claims and ensure that they have been documented and billed in accordance with DMAS policy. While providers' current practices may have resulted in improved documentation and more accurate billing, claims in the past may still have been paid improperly. In addition, DMAS staff clarified that providers have an opportunity to re-bill when there is "legitimate" billing error (numbers transposed, etc.); however, this correction cannot go back past the "lock-in period" for MMIS. DMAS agreed to follow-up internally to determine if extending the timeframe for re-billing is feasible. Lastly, reviewing claims within the current twelve-month billing cycle would substantially compress the time period for auditors to analyze and identify claims to audit, request documentation, and conduct

reviews. It would also reduce the time that providers have to conduct internal quality assurance reviews to identify and correct missing or incomplete documentation.

Item 3: Partial retraction and substantial compliance

Providers indicated a desire generally for DMAS to develop an audit methodology that applies different weights to different elements of the case record. Discussion included examples of case situations identified by some members of the advisory committee. Providers discussed an example in which the daily case notes and monthly summaries are completed every day for three months; however, the quarterly review is not in the record. In that case, the retraction is made for the entire quarter. Representatives of vaACCSES suggested that this be treated as a licensing issue since they believe that it is important to DBHDS but does not substantiate that a retraction is necessary since the services for which DMAS is paying have been rendered and documented. If DMAS does continue to audit this requirement, Virginia Association of Hospice Care Providers (VAHCP) noted that providers would prefer in these types of situations that some weight be given to the value of things like a quarterly review, rather than retracting payment for the entire quarter. A member of the advisory group agreed to forward to DMAS a document from 2008 regarding weights for various errors. DMAS noted that the quarterly review is required under DMAS policy but agreed to examine this methodology and determine if it is appropriate to apply to the audit process. DMAS received this letter on September 14, 2012, and is currently reviewing it to determine the feasibility of applying such a methodology to DMAS audits.

DMAS and PHBV clarified again that retractions are made 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 weeks 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.

Representatives of vaACCSES and other groups noted a desire that, in cases where the medical record lacks required documentation, DMAS accept other evidence that the care has been provided rather than making a retraction. VAPCP, VADHSA, and vaACCSES also expressed concern that they are unable to correct errors, such as missing signatures, if they are found through internal provider quality controls before an audit is conducted.

DMAS clarified that "late entry documentation" is allowable under DMAS policy, whereby the provider amends the record to correct the error and notes the amendment with a date and signature prior to an audit. What is not allowable under DMAS policy is "post audit documentation," where a provider corrects the error only after it has been identified through an audit. DMAS and PHBV also noted that while the audits that they conduct may uncover quality of care issues and fraud, they are primarily for the purposes of financial review and verification. These types of audits rely on accurate and complete medical records to substantiate that services

were provided, and DMAS policy to retract in cases where required documentation is missing or incomplete must be applied uniformly.

In the area of substantial compliance, advisory group members expressed a desire for DMAS audits to examine a statistically-valid random sample of a provider's records, and evaluate the percentage of those records that meet the standards set forth in DMAS policies, regulations and manuals. VADHSA representatives suggested that if at least 80 percent of the claims reviewed have been documented and billed in accordance with DMAS policies, that provider should be deemed to be "substantially compliant," and would not be subject to any retractions for the claims that lack or have improper documentation. VADHSA expressed a belief that it is unreasonable to expect that every provider will be 100 percent compliant 100 percent of the time.

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. As noted earlier, DMAS and PHBV currently focus their audits on particular providers and/or claims that have a higher likelihood of containing improper payments based on risk evaluation and statistical analysis. Moving to a statistically-valid random sample would remove this targeted approach for the purposes of the audit results being representative of all paid claims that a provider has submitted during a particular period. As such, the results of these audits would be used to extrapolate findings to the universe of claims. Therefore, if an audited sample indicated that five percent of a provider's claims were improperly documented, DMAS would retract five percent of all payments to that provider for those service types over the audit period. Provider representatives were in agreement that extrapolation is not desirable, therefore deeming this issue moot.

Item 4: Audit review areas

There was overall agreement that training offered by provider associations is beneficial, but providers expressed a desire for more information on what constitutes a "complete file" that is acceptable to auditors. VADHSA in particular requested a list of common error codes with specific examples of deficiencies, as well as either a punch list of necessary elements, or an example of the type of file DMAS expects to see. DMAS committed to assisting providers by providing information on common error codes but noted that audits are not limited to these more frequent errors. DMAS and PHBV reiterated that audits are conducted based on requirements in statutes, regulations and provider manuals, which make up the comprehensive policy on appropriate documentation.

Item 5: Aide record vs. Plan of Care

Many HCBS services are provided under a variety of waiver programs. Services provided under these waivers are required to be set forth in a Plan of Care that enumerates the service types and number of hours of care required based on an assessment. VADHSA and others expressed a concern that individual circumstances may require deviation from the Plan of Care on certain days. This may result in the aide record, which is the daily documentation of services provided, differing slightly from the services set forth in the Plan of Care.

DMAS noted that aide records are important to justify provider billing for services. DMAS acknowledged that there may be variations in service provision on some days based on the individual's needs, but if these variations are persistent, the Plan of Care should be revised to reflect this change.

Item 6: Personal care/respite provided by family

Under the Virginia Administrative Code (12VAC 30-120-950 & 30-120-190) DMAS will only pay for personal care and respite services furnished by family members if there is "objective written documentation to why there are no other providers or aides available to provide the care." Providers expressed two particular concerns related to this regulation: 1) how family is defined; and 2) what constitutes objective written documentation.

DMAS clarified that "objective written documentation" will generally come from a physician or other healthcare provider. When audits have uncovered errors related to this documentation, it is either because no documentation exists, or the documentation indicates only that the individual desires to have these services provided by a family member, which is inadequate. DMAS agreed to further clarify these requirements in the EDCD Waiver regulations when open for public comments on October 8, 2012, and encouraged members to submit comments so that they could be addressed in the 60-day formal public comment period.

Summary of the Issues Discussion

Overall the advisory committee agreed that the climate of the discussions between DMAS and the provider community has significantly improved over the past three years. The main request of the group was that DMAS provide more guidance on the scope of the audits. DMAS' Divisions of Program Integrity and Long Term Care will collaborate to develop materials related to the frequent audit errors for use by providers to train staff at their organizations on correct billing practices.

ATTACHMENT I – Legislative Mandate

2012 Appropriations Act Language

Item 307 YYY. The Department of Medical Assistance Services shall establish an advisory group of representatives of providers of home- and community-based care services to continue improvements in the audit process and procedures for home- and community-based utilization and review audits. The Department of Medical Assistance Services shall report on any revisions to the methodology for home- and community-based utilization and review audits, including progress made in addressing provider concerns and solutions to improve the process for providers while ensuring program integrity. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2012.

ATTACHMENT II - 2012 Advisory Group Attendees

August 16, 2012 Meeting

AFFILIATION	NAME
Virginia Association for Home Care and Hospice (VAHC)	Marcia Tetterton
Virginia Association of Personal Care Providers (VA-PCP)	Bonnie Gordon
Virginia Association of Community Services Boards (VACSB)	Will Frank
Virginia Network of Private Providers, Inc (VNPP)	Ann Bevan
Virginia Association of Centers for Independent Living (VACILS)	Gerald O'Neill
Virginia Association of Community Rehabilitation Programs	Dave Wilber
Virginia Adult Day Health Services Association (VADHSA)	Dora Robertson
Virginia Association for Hospices & Palliative Care (VAHPC)	Brenda Clarkson
Department of Behavioral Health and Developmental Services (DBHDS)	Gail Rheinheimer
Department of Medical Assistance Services (DMAS)	Louis Elie
	Terry Smith
	Adrienne Fegans
	Helen Leonard
	Brad Marsh
	Nichole Martin
	Vanea Preston
	Jeff Nelson
	Elizabeth Smith
	Jeanette Trestrail
	Tracy Wilcox
PHBV Partners (formerly Clifton Gunderson)	JoAnn Hicks

September 13, 2012 Meeting

AFFILIATION	NAME
Virginia Association for Home Care and Hospice (VAHC)	Marcia Tetterton
Virginia Association of Personal Care Providers (VA-PCP)	Bonnie Gordon
Virginia Association of Community Services Boards (VACSB)	Carol McCarthy/Will Frank
Virginia Network of Private Providers, Inc (VNPP)	Jennifer Fidura/Ann Bevan
Virginia Association of Centers for Independent Living (VACILS)	Gerald O'Neill
Virginia Association of Community Rehabilitation Programs	Dave Wilber
Virginia Adult Day Health Services Association (VADHSA)	Dora Robertson
Department of Behavioral Health and Developmental Services (DBHDS)	Gail Rheinheimer
Department of Medical Assistance Services (DMAS)	Louis Elie
	Terry Smith
	Adrienne Fegans
	Helen Leonard
	Brad Marsh
	Vanea Preston
	Jeff Nelson
	Elizabeth Smith
	Jeanette Trestrail
	Tracy Wilcox
PHBV Partners (formerly Clifton Gunderson)	JoAnn Hicks

ATTACHMENT III - Advisory Group Comments

a Grace PLACE
ADULT CARE CENTER

TO: ADRIENNE FEGANS
FROM: LYNNE SEWARD – CEO & DORA ROBERTSON - ACCOUNTANT
SUBJECT : COMMENTS 12/1/12 DMAS ADVISORY GROUP DRAFT
DATE: NOVEMBER 6, 2012

BELOW PLEASE FIND OUR COMMENTS CONCERNING THE HOME AND COMMUNITY BASED SERVICES AUDIT METHODOGY REPORT DATED 12/1/2012

- **Provider**s have requested **training** and guidance from DMAS concerning the expectations of the Auditors. It was noted by DMAS that there are many different scenarios; hence it would be difficult to provide "Best Practice" or top areas of non-compliance. However, we, as Providers, **need to provide training tools** to our staff. Support, guidance and training are essential in providing appropriate, accurate, complete, and compliant information.
- We have asked for information concerning common **error codes**. Again, there are many types of errors, however, in our meetings; we received only a general list of common errors, i.e., Criminal Background Checks, Training, Licensing, Missing Plans of Care, Signatures. The Providers would appreciate some type of reference **sheet or an example of a complete file** that would be acceptable to the Auditors.
- We would like the ability to **"fix" missing documentation** or have the opportunity to provide other acceptable paperwork before the item lands on an Overpayment Report. In addition, with the audit period more current (i.e., covers 12 months rather than 18 months) if the claim is over 1 year old, we still cannot resubmit. We would like to have the opportunity to provide a **late entry correction** via a re-transmittal. As noted in the draft, providers suggest that the audit period cover 6 months rather than 12 months because of the massive amount of paperwork and labor required to pull a client's information for an entire year.

- We remain at odds concerning **Substantial Compliance**. It has been suggested that if a Provider is compliant, for example, 80% of the time, we should be considered compliant. It is **unreasonable to hold everyone to 100% compliant 100% of the time**. It has also been requested that noncompliance and retractions be based upon scope and severity. Currently, levels of noncompliance (minor infractions) result in harsh retractions, even though they are not an indication of quality of service or fraud.
- It was mentioned that the Plan of Care requirements for an individual may change. If a client, for example, is to "receive a bath daily", but the client simply says "I don't want a bath today", **variations to a Plan of Care should be considered**.
- We would hope that the Audits become **less punitive to the "Good Providers"**.

As a provider, we appreciate the opportunity to sit "face to face" to discuss our common objective; ensuring the safety and care of our clients. Though this mission is quite clear, showing that the individual is receiving proper care has become dependent on whether a particular document exists. This is acceptable ONLY IF the provider and DMAS are clear on that documentation. As a provider, our goal is to maintain precise records validating and confirming the exceptional care we give. In reality, it seems that we are measuring clerical accuracy as confirmation of quality of care. The Audit Methodology process has helped bridge the gap between client well being and the fiscal responsibility we all have for the accurate distribution of funding for the services rendered.

Thank you so much for the opportunity to comment. If you should have any questions, please feel free to contact Lynne Seward or Dora Robertson at 804-261-0205.

VAHPC Comments re Home and Community-based Services Audit Methodology Report

Thank you for the opportunity to respond to the draft report. On behalf of its hospice provider members, VAHPC offers the following comments.

Item #: Partial Retraction and Substantial Compliance

Our concern is related to retractions. As stated "retractions are made for the number of units found to be out of compliance, based upon documentation and billing practices".

For the purpose of clarification please note:

1. Hospices provide care based on a plan of care which identifies individual care and services to be provided including all home visits by physicians, nurses, social workers, chaplains, counselors, hospice aides, and volunteers plus the provision of 24 hour on-call availability, pharmaceuticals, medical supplies, HME, and one year of bereavement services to family members following the patient's death.
2. Hospices are reimbursed on a per diem rate which is intended to cover all the services listed above.

Our concern centers around the retraction methodology based on recouping fees for services that were identified as non-compliance with DMAS requirements from providers that are reimbursed, not on fee-for-service basis, but on a per diem model. I believe an example will best illustrate our concern -

In a recent audit a hospice was found to be in error with respect to hospice aide visits when one visit was missed. The auditors concluded that the plan of care was not being followed as it required 3 hospice aide visits per week for one month and therefore retracted the units for one month.

Our concern relates to the definition of the "unit". The error was identified in hospice aide visits which for this hospice are quantified as having a value of $55. This is based on the per visit charge that CMS requires each hospice to calculate for cost reporting purposes (and it is also listed on claims made to Medicare even though reimbursement is on a per diem basis).

The financial impact of the recommended retraction is outlined below

The actual error identified by the audit is valued at ($55 x 3) x 4 = $660.00

Retraction based on per diem rate (of approximately) $150 x 30 days = $4,500.00

Our concern is that retracting full per diem rates for errors that relate to only a small component of the services provided and covered by this rate is unfair and results in punitive retractions.

Thank you again for this opportunity to comment.

Sincerely,

Brenda Clarkson

Brenda Clarkson
Executive Director

The Virginia Association for Hospices and Palliative Care
Post Office Box 70025 • Richmond, VA 23255-0025 • Phone (804) 740-1344 • Fax (775) 599-2677
Email info@virginiahospices.org

Virginia Network of Private Providers, Inc.
804 Moorefield Park Drive, Suite 201
Richmond, Virginia 23236
vnpp@earthlink.net
http://vnppinc.org

Comments on Draft Report on Audit Methodology for HCBS (307YYY)

VNPP agrees with the Summary provided in the report that "The climate of the discussion between DMAS and the provider community has significantly improved over the past three years;" however, there continue to be areas of disagreement and absent specific direction from the General Assembly to continue discussion there may not be a platform for continued dialog.

As noted in Discussion Item #3 there is further work to be done on the issue of "substantial compliance." We agree that the current practice of retraction for only the units for which documentation is lacking or insufficient is a significant improvement over the previous practice of retracting for the entire claim if the documentation to support billing was lacking for any unit of service within the billed claim. There is, however, an issue which warrants further discussion; the practice of retraction when only one of several layers of documentation is lacking.

For example:

- Services are provided and are sufficiently documented with daily notes, logs and/or other records, but a monthly review of the progress which is also required is missing.
- Services are provided and are sufficiently documented appropriately with daily notes, logs and/or other records, and the monthly review of the progress which is also required is completed properly, but the documentation of the required staff training is missing.

In each of the above cases, the retraction would be for all of the services described. We would suggest that when the missing "layer" is not the primary documentation, the audit expand to check for the missing element in other records. If the problem is pervasive, the retractions would occur; if, however, the problem is an anomaly the retraction would not occur.

VNPP would like to continue to participate in regular meetings with DMAS Provider Integrity staff to discuss audit issues on both HSBC services and CHMRS services.

Thank you for the opportunity to comment. If you have questions, you may contact Jennifer G. Fidura, Executive Director, at 804-560-4640.

vaACCSES

Virginia Association of Community Rehabilitation Programs

November 6, 2012

Ms. Cindi Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

Thank you for the opportunity to provide comment on the draft report required by Item 307 YYY on behalf of the vaACCSES. Because of the short turnaround time, my comments will focus on two overall themes/issues.

Provider Selection

As you know, the private sector has been disproportionately hard hit by the downturn and slow recovery of Virginia's economy. An unintended consequence of repeated audits imposed on the same large providers or providers that disproportionately provide services to high cost individuals ultimately impacts the capacity of the private providers to maintain quality in an already underfunded system of care. We recommend that the audit selection methodology used be one that specifically relates to Virginia's changing program goals and incentives and does not disproportionately punish providers that strive to serve the more difficult and needy waiver recipients. We also recommend that the methodology used select a genuine cross section of large and small providers as well as new and long-standing providers.

Retraction and Substantial Compliance

The members of vaACCSES understand that Virginia, like all other states, must monitor and control waste, fraud and abuse within the Medicaid program. However, we believe that the retraction of funds for a service that has obviously been provided because of administrative error or omission is not an appropriate measure to control waste, fraud, or abuse. Nor is it a particularly effective way to promote quality services for those with significant disabilities.

One example may include a case situation in which daily case notes and monthly summaries are completed correctly each day for three months. However, the quarterly review is not in the record. Often, the retraction is made for the entire quarter. Our recommendation during the provider advisory meeting, but not referenced in the draft report, is that this be a licensing issue since it is important to DBHDS but does not substantiate that a retraction is necessary since DMAS is paying for services rendered and documented.

We look forward to working with you as you review ways that Virginia can provide quality programs, maintain the integrity of the community provider system, and still abide by the formal Medicaid rules.

Sincerely,

Karen Tefelski

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

From: Bonnie Gordon [mailto:bgordon@familycareinc.net]
Sent: Tuesday, November 13, 2012 11:18 AM
To: Preston, Vanea (DMAS)
Subject: RE: Audit Methodology

Item 1&2- It is stated that if the audit span was moved to a 6 month review period the # of cases would not change. Providers acknowledged that the # of records would have to increase in order to capture a sufficient amount of claims constituting a reasonable sample.

The comment about having a longer period to have the ability to see growth and improved in compliance of the provider can be accomplished by choosing varying 6 month periods, some closer to the time of the audit and some older.

Providers continue to want the audit sample to be chosen more contemporaneously.

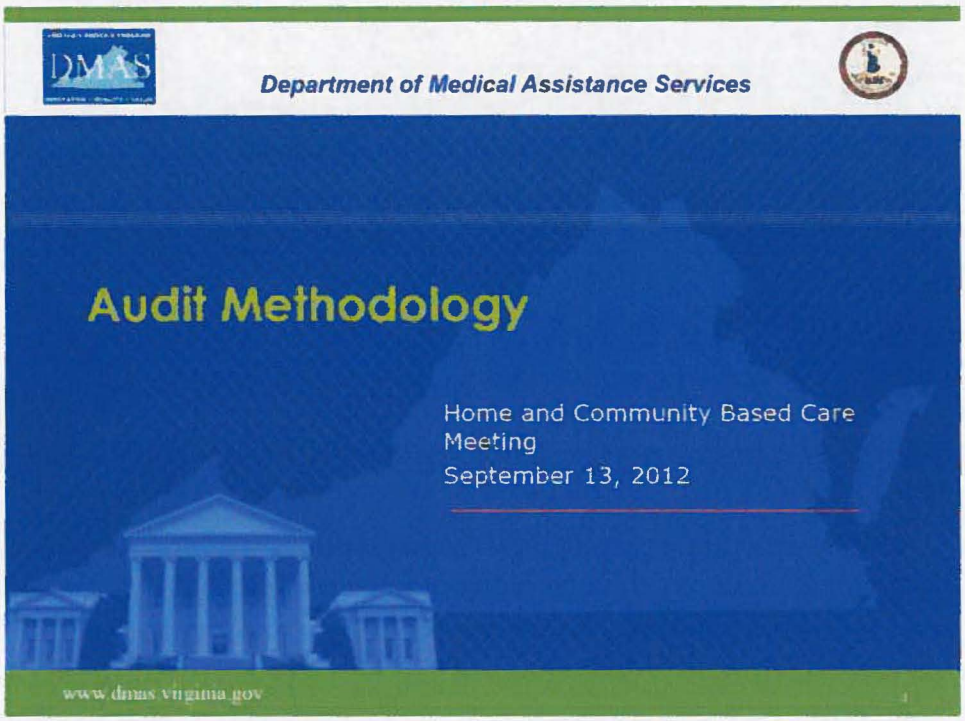
Item 3- the comment that DMAS has reviewed the methodology and believes the meetings addressed the question of partial retraction and substantial compliance is still unclear. How has it addressed this? We see your example of the 1 month billing cycle; however, providers are still losing an entire week of reimbursement if a signature is missing without the ability to get the signature post audit. We continue to question the DMAS policy that prohibits any post audit documentation additions. We understand that all late entry documentation has to be done correctly and post dating documentation cannot is acceptable.

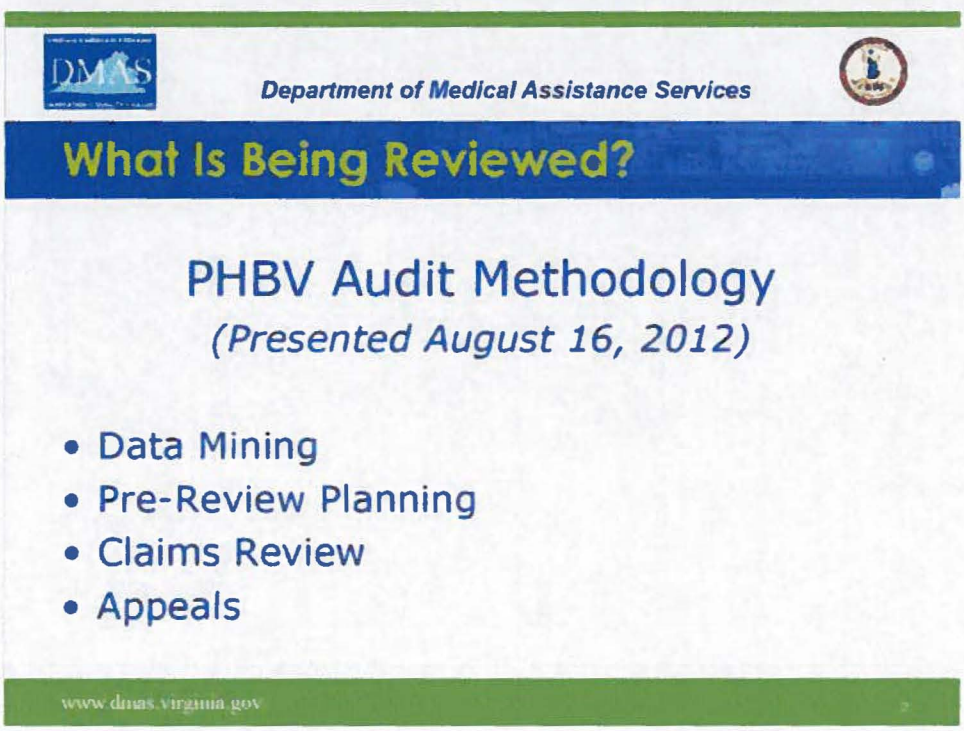
We appreciate a seat at this table and DMAS's willingness to listen to our concerns. We agree that the reduction from 15 month to 12 months is an improvement. We also appreciate the department's willingness to offer training in conjunction with association meetings. The tone at these meetings was very collaborative, and providers appreciate the willingness of DMAS to listen to our concerns. We also appreciate DMAS's willingness to further define billing errors and allow us the opportunity to enhance provider training and compliance.

Bonnie Gordon
Policy Chair of the Virginia Association of Personal Care Providers

413 Stuart Circle, Suite 120
Richmond, VA 23220
804-288-2111

ATTACHMENT IV - PHBV Presentation on Commonly-Found Errors





Virginia Information Technologies Agency

Home Health

www.vita.virginia.gov

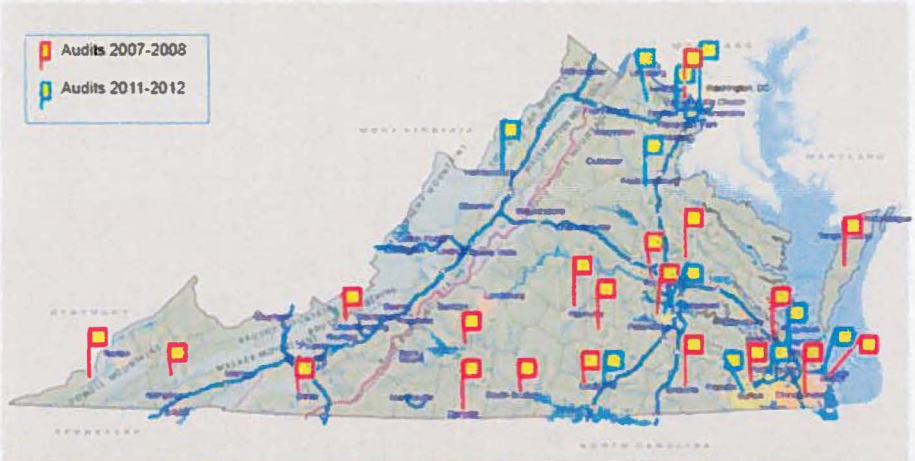
Virginia Information Technologies Agency

Hospice

www.vita.virginia.gov

Virginia Information Technologies Agency

Personal Care / Respite Care



www.vita.virginia.gov

Department of Medical Assistance Services

What Is Being Reviewed?

All Review Procedures are derived directly from the requirements as written in the *VAC* and *DMAS Program Manuals*

www.dmas.virginia.gov

Department of Medical Assistance Services

What Is Being Reviewed?

All reviews are performed to determine compliance with:

- Staffing requirements
- Requirements for admission documentation
- Requirements for documentation of services rendered
- Requirements of supervisory activities
- Services documented in accordance with Plan of Care
- Reconciliation of documented services to those billed & paid

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

www.dmas.virginia.gov

Department of Medical Assistance Services

Staffing Requirements

Common Errors & **General Compliance**

- Criminal background checks
- Reference checks
- 12 hours in-service training per year
- Family members
- RN/LPN licensing

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

www.dmas.virginia.gov

Department of Medical Assistance Services

Admission Documentation

Common Errors &

- The completed DMAS-96 (Pre-Admission Screening Authorization) and/or DMAS-97 (Screening Team Plan of Care) is not in the recipient's file

General Compliance

- Physician's signature obtained prior to start of services
- Authorizations obtained

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

Department of Medical Assistance Services

Documentation of Services Rendered

Common Errors &

- Aide comments on DMAS-90
- Signatures on DMAS-90 (missing, dating issues, and/or authentication issues)
- Altered records

General Compliance

- Services documented in accordance with plan of care
- Times in/out completed
- Properly maintained records

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

Department of Medical Assistance Services

Supervisory Activities

Common Errors & **General Compliance**

- Supervisory visit not completed every 30-90 days
- Review of Aide records & proper corrections

- Plans of care prepared and updated

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

Department of Medical Assistance Services

Plan of Care

Common Errors & **General Compliance**

- Not within 10 most common errors!

- Plans of care prepared and updated
- Services documented in accordance with plan of care

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

Department of Medical Assistance Services

Reconciliation: Documented vs. Paid

Common Errors

- The provider has billed more units than the documentation shows were provided

&

General Compliance

- Properly maintained records

These are the typical areas covered during a review, and the typical findings. It should not be interpreted as an all-inclusive list of review procedures.

Department of Medical Assistance Services

What Is Being Reviewed?

Remember to consult the *VAC* and *DMAS Policy Manual* regularly