COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 10, 2014

MEMORANDUM

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

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones

SUBJECT: Report on Audits of Home-and Community-Based Services

The 2013 Appropriation Act, Item 307 NNNN, states:

> *The Department of Medical Assistance Services shall establish a work 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. In addition, the report shall include documentation of the past year's audits, a summary of the number of audits to which retractions were assessed and the total amount, the number of appeals received and the results of appeals. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by December 1 of each year.*

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

CBJ/

Enclosure

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

Department of Medical Assistance Services
Annual Report to the General Assembly

Report on Audits of Home- and Community-Based Services

December 2013

Report Mandate

The 2013 Appropriation Act, Item 307 NNNN, states:

> *The Department of Medical Assistance Services shall establish a work 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. In addition, the report shall include documentation of the past year's audits, a summary of the number of audits to which retractions were assessed and the total amount, the number of appeals received and the results of appeals. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by December 1 of each year.*

Background

Home and Community Based Services (HCBS) are provided to individuals enrolled in Medicaid who meet criteria for admission to a 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.) The Department of Medical Assistance Services (DMAS) operates six 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, DD and DS waivers are administered by the Department of Behavioral Health and Developmental Services (DBHDS).

A variety of services are provided to individuals enrolled in HCBS waivers, based on their care needs, available family and community support, 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 their care needs are met while living 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. This report will not address program integrity activities related to consumer-directed services, as these are conducted by the contracted fiscal employer agent and are not analogous to audits conducted by the Program Integrity Division (PID) and Myers and Stauffer LC (Myers & Stauffer).

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.

Quality Management Reviews (QMRs)

The primary focus of QMRs is to meet Centers for Medicare and Medicaid Services (CMS) requirements for HCBS waiver 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) DMAS assure that necessary safeguards have been taken to protect the health and welfare of the recipients of services; 2) assure 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. QMR does not directly result in payment retractions, though subsequent Provider Review Unit audits may identify recoverable overpayments.

Utilization Review and Financial Review and Verification (Audits)

Audits are conducted by internal DMAS Program Integrity staff and their contractor, Myers & Stauffer. 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. 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."*

The Virginia Administrative Code 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 audits. 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. Audits rely on

documentation to determine whether the services delivered were appropriate, continue to be needed, and are in the amount and kind required.

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.

Audit Methodology Workgroup

Pursuant to Budget direction, DMAS has worked with providers to establish an advisory group of representatives of HCBS providers and held meetings in the summers of 2011 and 2012. Details on the activities of this workgroup in prior years can be found in DMAS' 2011 report, *Evaluation of Effectiveness and Appropriateness of Review Methodology for Home and Community Based Services,* and 2012 *Report of the Activities of the DMAS Advisory Group on Audit Methodology for Home- and Community-Based Services.* DMAS convened this workgroup again on July 24, 2013, to discuss changes made to the DMAS audit process pursuant to prior meetings and to provide a forum for providers to express their concerns with DMAS audits. As in prior years, this advisory group included representatives from groups representing major providers of HCBS, DMAS Program Integrity and Long Term Care staff, DMAS contract auditor staff, as well as representatives of the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

DMAS opened the meeting with a discussion of changes that have been made in HCBS regulations and audits. DMAS Director of Long-Term Care, Terry Smith, discussed QMRs and how they examine CMS assurances and provide training and education on deficiencies in quality, but do not result in any retractions. In addition, she informed the group that the final regulations for the EDCD waiver were currently at the Office of the Attorney General for review.

DMAS Program Integrity Division (PID) Director, Louis Elie, gave an overview of changes that have been made to the audit process pursuant to prior year meetings. DMAS has shortened the review period on all audits to 12 months, where some audits had looked at a 15-month period in the past. In addition, DMAS has made efforts to ensure that all providers are considered for review regardless of size by stratifying large and small providers based on their total Medicaid billings for the audit period. The PID Director also informed the group of the implementation of the federally-required Recovery Audit Contractor (RAC) program in Virginia in FY 2013. He directed the group to the RAC website where additional materials on the program are available.

The discussion then focused on four major areas identified by the stakeholders: 1) increased clarity in communication of audit findings; 2) reasonable threshold and substantial compliance; 3) audit stratification and provider selection; and 4) use of telephony and other technology. The following section gives an overview of the workgroup's discussion.

Workgroup Discussion Topics

1) Increased clarity in communication of audit findings

Stakeholders expressed a desire for greater clarity in regards to the letters sent to providers by Myers & Stauffer regarding the errors and overpayments found during an audit. They stated that the letters only broadly lay out the errors that were committed and the regulatory, contract or provider manual language that was violated. As a result, some stakeholders found it difficult to identify specific errors on particular claims.

Myers & Stauffer noted that the letter is accompanied by a compact disc that lays out the errors identified on each individual claim, which should allow providers to identify those issues in more detail. In addition, Myers & Stauffer stated that they conduct an exit conference after each audit at which providers can request greater clarity on the errors identified. They suggested that providers ensure that the appropriate staff members are present during the exit conference to avoid miscommunication on the nature of the errors. Myers & Stauffer also agreed to work with providers to ensure that spreadsheets contain information in an easy to use format, and conduct any training on these documents that providers request.

2) Reasonable threshold and substantial compliance

Stakeholders expressed the opinion that the current documentation requirements used for audits are too punitive, as a single missing signature or form can invalidate an entire period of care. Stakeholders also suggested that providers be allowed to submit daily records, so that missing documentation would only invalidate claims for that day. Hospice representatives stated that their providers can be subject to retractions for an entire quarter if the required quarterly review is not in the medical record, even if monthly reviews are in the record for all months in the quarter, and that the monthly reviews should be sufficient.

DMAS staff noted that they would be open to allowing daily notes instead of weekly notes, but that regulatory changes would need to be made to allow documentation in this manner. DMAS and Myers & Stauffer 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.

In addition, stakeholders asserted that DMAS should be using a standard of "substantial compliance," which they claim is utilized by Medicare. This standard of "substantial compliance" would allow DMAS to retract payment only in cases where it appears that services were not provided, regardless of whether they have met all documentation requirements for those services. Lastly, stakeholders suggested that federal regulations permit DMAS to take only partial retraction for cases.

DMAS stated that pursuant to guidance from CMS as well as the Virginia Office of the Attorney General (AG), if there is no documentation of billed services being provided, DMAS must implement a total retraction for the services billed. Neither DMAS nor the AG has found federal or state regulations indicating otherwise. DMAS staff examined federal regulations for references to a "substantial compliance" standard and found that such a standard is only cited in reference to quality reviews.

Stakeholders also asserted that DMAS can implement partial retractions based on a reference to 42 CFR 455.23 which states:

> *A State may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud…*

This section of federal regulations, however, is not in reference to state retractions based on post-payment audits, but instead to CMS-required prospective suspension of payments to providers in cases where there is a "credible allegation of fraud."

3) Audit Stratification and provider selection

Stakeholders asked DMAS and Myers & Stauffer staff to explain the process by which providers are selected for audit. DMAS staff explained how providers are chosen for DMAS audits. Data mining is conducted on prior year claims to determine providers who are outliers on a variety of measures, not merely outliers in total billed claims. For example, analysis may look at number of service units per recipient or providers with higher than average use of certain high-level procedure codes. Providers are stratified for these analyses and compared against their peer groups. Once providers are identified as outliers, DMAS utilizes a vetting spreadsheet to ensure that providers are not subject to overlapping audits and have not been reviewed in recent audit cycles.

In addition to audits conducted by DMAS staff, DMAS also contracts with Myers & Stauffer to conduct additional audits of providers. The first step of the Myers & Stauffer audit process involves running claims through a proprietary data mining software program that is customized for use with DMAS data to find trends of interest. Examples of trends of interest include unusual increases or decreases in claims volume, per-

recipient billings that are out of line with similar providers, 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.

Stakeholders expressed some concern that the DMAS provider selection process results in larger providers being targeted while smaller providers are not audited. The table below shows the breakdown of Myers & Stauffer (MSLC) and Provider Review Unit (PRU) audits of HCBS providers for FY 2011 and FY 2012 by the total dollars in claims filed by selected providers during the audit review period. As is evident from this table, although providers of all sizes were audited, the majority of audits (64%) were conducted on providers with $100,000 to $1 million in claims, which are also the categories in which majority of providers fall.

Table 1: Number of Audits by Provider Billing Volume, FY 2011-2012.

Fiscal Year Audit Conducted	Total Audits Conducted	Providers with less than $50K in Claims	Providers with $50K to $100K in claims	Providers with $100K to $1M in claims	Providers with greater than $1M in claims
FY 2011 MSLC	100	8	12	60	20
FY 2011 PRU	39	14	5	11	9
Total FY 2011	139	22	17	71	29
FY 2012 MSLC	135	40	17	64	14
FY 2012 PRU	24	9	3	11	1
Total FY 2012	159	49	20	75	15
Total	**298**	**71**	**37**	**146**	**44**

Stakeholders also inquired as to the type of follow-up that is conducted by DMAS on audits with major findings. DMAS staff stated that a year after an audit is completed, DMAS reviews the audited providers to determine if issues continue to exist. If DMAS finds that the issues continue to exist, DMAS staff conducts provider education. Stakeholders asked if prior audits are examined when a provider comes up for review again. DMAS staff stated that they review previous audits to determine the education the provider has undergone. If the provider continues to have the same issues, this may indicate fraud.

Stakeholders then asked if DMAS adjusts their audits when findings do not hold up on appeal. Stakeholders stated that providers assume that if a finding does not hold up under appeal, that it should not be the focus of future audits. DMAS agreed and noted that they have adjusted their audit practices when certain findings have been deemed invalid upon appeal. It is important to note that not all overpayment reductions resulting from appeals are due to findings being deemed invalid; rather some reversals are based on technical issues, such as an insufficient case summary. Audit practices would not change when a

reversal is based on a technical issue rather than on the merits of the case. In addition, DMAS permits providers to submit additional documentation that supports the original payment throughout the appeals process, which also results in overpayment reductions that do not invalidate DMAS audit standards.

Stakeholders inquired as to how Myers & Stauffer determines the number of records to be examined. Myers & Stauffer stated that generally, a sample of 30-35% of the providers' claims for that period are reviewed, though some smaller providers with few recipients may have higher proportions of their claims reviewed. On average, in FY 2011 and FY 2012, Myers & Stauffer audited 33 and 30 percent of audited provider claims, respectively.

4) Use of telephony and other technology

Stakeholders asked if providers are allowed to use telephony or other technology-based documentation methods. DMAS staff stated that a pilot was conducted several years ago but was unsuccessful. Use of this technology is not prevented by regulations; however, DMAS is not set up to have these systems report directly into MMIS. Stakeholders inquired as to whether the records created by these types of systems would be allowable as documentation of services being provided. DMAS staff responded that if providers desired to move in this direction, some regulatory changes might be required, but DMAS would be open to further exploration.

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. DMAS will continue to work to address the concerns of providers while maintaining the fiscal integrity of the Medicaid program in Virginia.

Summary of HCBS Audit Activity

In addition to a discussion of the activities of the advisory workgroup, Item 307 NNNN directs DMAS to report on the outcomes of prior year audits of HCBS providers, including audit findings and appeals results. The following section presents the results of audits conducted in FY 2011, FY 2012, and FY 2013. Because of the duration of the appeals process, only those audits conducted in FY 2011 and FY 2012 have reliable information on appeals outcomes.

Myers & Stauffer Audit Results

Myers & Stauffer conducted a total of 235 audits of HCBS providers over two fiscal years; FY 2011 and FY 2012. Audited providers had total billings of more than $129 million during the audited period. Myers & Stauffer audited a total of 64,266 claims representing approximately $30 million of billings for HCBS services. The following table gives a breakdown of these statistics for each of the fiscal years.

Table 2: Billings of Providers Audited by Myers and Stauffer, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits Conducted	Total Claims Submitted by Audited Providers	Total Billings by Audited Providers	Total Claims Audited	Total Billings of Audited Claims
FY 2011	100	168,586	$76,634,571	27,163	$14,361,176
FY 2012	135	152,412	$53,162,515	37,103	$15,832,794
Total	235	320,998	$129,797,086	64,266	$30,193,970

Myers & Stauffer looked at a wide variety of HCBS providers in its audits. The following table shows the number of audits conducted in FY 2011 and FY 2012 on each HCBS provider type.

Table 3: Provider Types Audited by Myers and Stauffer, FY 2011-2012

Provider Type	FY 2011	FY 2012	Total
ID Waiver	15	16	**31**
Personal Care	35	37	**72**
Respite Care	26	26	**52**
PDN	10	10	**20**
Home Health	9	11	**20**
Hospice	5	5	**10**
Adult Day Healthcare	-	5	**5**
Congregate Living (ID)	-	7	**7**
Service Facilitator	-	18	**18**
Total	**100**	**135**	**235**

The 235 audits conducted by Myers & Stauffer identified a total of $10,508,779 in improper payments, or about a third of the total dollars audited. This equates to an average of $44,718 in overpayments identified per audit. It is important to note that the dollar amounts in error in the table are reflective of reductions of $871,036 in FY 2011 and $785,472 due to DMAS' policy of allowing providers to submit additional documentation to correct errors identified at the preliminary review stage before a final overpayment letter is issued.

Table 4: Myers and Stauffer Audit Findings, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits Conducted	Total Claims Audited	Total Dollars Audited	Total Claims in Error	Total Dollars in Error
FY 2011	100	27,163	$14,361,176.39	13,077	$5,361,334.18
FY 2012	135	37,103	$15,832,794.45	19,642	$5,147,444.90
Total	235	64,266	$30,193,970.84	32,719	$10,508,779.08

While Myers & Stauffer audits uncovered around $45,000 in overpayments on average, there was substantial variance from that number in the results of individual audits. Forty HCBS audits or about 17 percent of audits conducted, resulted in less than $1,000 in

overpayments. In addition, only 35 audits resulted in findings of greater than $100,000. The following table gives a breakdown of audit findings by fiscal year.

Table 5: Myers and Stauffer Audits by Amount of Findings, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits Conducted	Total Audits with Findings	Total Audits with findings >$1000	Total Audits with findings >$10,000	Total Audits with findings >$100,000
FY 2011	100	96	87	65	17
FY 2012	135	125	108	72	18
Total	235	221	195	137	35

Of the 221 audits conducted in FY 2011 and FY 2012 in which there were findings, 100 were appealed to the Informal Fact Finding Conference (IFFC) level. Of those 100 appeals, 31 resulted in a reduction of the overpayment findings of the original audit. A substantial proportion of the reductions at IFFC were due to the provider producing additional documentation, with that being the only reason for the reduction in 15 of the 31 cases.

Table 6: Results of IFFC Appeals of Myers and Stauffer Audits, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits with Findings	Total Appealed	Total Dollars Appealed	Total Reduced at IFFC	Total reduction in overpayments (IFFC)
FY 2011	96	31	$2,655,048.85	11	$63,492.42
FY 2012	125	69	$4,042,577.49	20	$544,986.07
Total	221	100	$6,697,626.34	31	$608,478.49

After IFFC, the next level of the appeals process is the formal appeal. Thirty-four providers appealed to this level, with a total overpayment amount of $3,074,536 being appealed. Twelve of those 34 cases resulted in additional reductions to the overpayments identified in the original audit, with a total of $865,010 in overpayments being reduced.

Table 7: Results of Formal Appeals of Myers and Stauffer Audits, FY 2011-2012

Fiscal Year Audit Conducted	Total Formal Decisions	Total Amount Appealed to Formal	Total Reduced at Formal	Total reduction in overpayments (Formal)
FY 2011	21	$1,801,470.83	9	$599,800.90
FY 2012	13	$1,273,065.92	3	$265,209.63
Total	34	$3,074,536.75	12	$865,010.53

DMAS Provider Review Unit (PRU) Audit Results

PRU conducted 63 audits of HCBS providers in FY 2011 and FY 2012. Audited providers had total billings of more than $33.7 million for the audit period. PRU audited claims totaling $6.8 million in HCBS services. The following table gives a breakdown of these statistics for each of the fiscal years.

Table 8: Billings of Providers Audited by PRU, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits Conducted	Sampled Provider $	Total Billings of Audited Claims
FY 2011	39	$24,951,960.52	$4,787,205.04
FY 2012	24	$8,824,478.18	$2,018,273.29
Total	63	$33,776,438.70	$6,805,478.33

PRU audits four types of HCBS providers, ID Waiver; Personal Care; Respite Care; and Private Duty Nursing. The following table shows the number of audits conducted in FY 2011 and FY 2012 of each HCBS provider type.

Table 9: Provider Types Audited by PRU, FY 2011-2012

Provider Type	FY 2011	FY 2012	Total
ID Waiver	18	0	**18**
Personal Care	13	12	**25**
Respite Care	7	11	**18**
PDN	1	1	**2**
Total	**39**	**24**	**63**

The 63 audits conducted by PRU involved providers who had been paid a total of $33,776,439 for the audit review period. These audits included claims that represented $6,805,478 in billings of which $1,126,465, or about 16 percent of the total audited payments, was found to be in error. This equates to an average of $17,880 in overpayments identified per audit. Please note that the "Total Dollars in Error" is reflective of any reductions resulting from DMAS' policy of allowing providers to submit additional documentation to correct errors identified during the preliminary review stage. A breakout of those figures by fiscal year is displayed in the table below.

Table 10: PRU Audit Findings, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits Conducted	Amount Paid to Audited Providers	Total Dollars Audited	Total Dollars in Error
FY 2011	39	$24,951,961	$4,787,205	$842,004
FY 2012	24	$8,824,478	$2,018,273	$284,461
Total	63	$33,776,439	$6,805,478	$1,126,465

While PRU audits in FY 2011 and FY 2012 uncovered around $18,000 in overpayments on average, there was substantial variance from that number in the results of individual audits. Thirty-one HCBS audits, or about half of audits conducted resulted in less than $1,000 in overpayments, with 16 audits identifying no erroneous payments. In addition, only two audits resulted in findings of greater than $100,000. The following table gives a breakdown of audit findings by fiscal year.

Table 11: PRU Audits by Amount of Findings, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits Conducted	Total Audits with Findings	Total Audits with findings >$1000	Total Audits with findings >$10,000	Total Audits with findings >$100,000
FY 2011	39	27	20	13	2
FY 2012	24	20	12	7	0
Total	63	47	32	20	2

Of the 47 audits conducted in FY 2011 and FY 2012 in which there were findings, nine were appealed to the Informal Fact Finding Conference (IFFC) level. Of those nine appeals, three resulted in a reduction of the overpayment findings of the original audit with a total reduction of $6,133, less than 2.5 percent of the total dollars appealed.

Table 12: Results of IFFC Appeals of PRU Audits, FY 2011-2012

Fiscal Year Audit Conducted	Total Audits with Findings	Total Appealed	Total Dollars Appealed	Total Reduced at IFFC	Total reduction in overpayments (IFFC)
FY 2011	27	5	$152,313	2	$4,647
FY 2012	20	4	$97,339	1	$1,486
Total	47	9	$249,652	3	$6,133

After IFFC, the next level of the appeals process is the formal appeal. Four providers appealed to this level, with a total overpayment amount of $123,283 being appealed. None of those four formal appeals resulted in reductions to the overpayments identified in the original audit.

Table 13: Results of Formal Appeals of PRU Audits, FY 2011-2012

Fiscal Year Audit Conducted	Total Formal Decisions	Total Amount Appealed to Formal	Total Reduced at Formal	Total reduction in overpayments (Formal)
FY 2011	2	$88,951	0	-
FY 2012	2	$34,331	0	-
Total	4	$123,283	0	-

Conclusion

Over the past years, this advisory committee has provided an opportunity for the HCBS provider community to share their concerns about the DMAS audit process with DMAS staff and contractors. DMAS has worked to understand these concerns and has made several changes to the audit process as a result. The reduction of the review period to twelve months for all audits, as well as efforts to ensure that audits include large and small providers are examples of these efforts. Pursuant to this year's meeting, DMAS and Myers and Stauffer have committed to working with providers to make the documentation of audit findings more clear and easy-to-use, and will continue to work with providers to ensure that the audit process is fair and straightforward.

ATTACHMENT I – 2013 Advisory Group Meeting Attendees

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)	
Virginia Network of Private Providers, Inc (VNPP)	Jennifer Fidura Ann Bevan
Virginia Association of Centers for Independent Living (VACILS)	Debbie Fults
Virginia Association of Community Rehabilitation Programs (vaACCSES)	Dave Wilber(phone) Karen Tefelski
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
	Gerald Craver
	Brad Marsh
	Chris Callaway
	Vanea Preston
	Elizabeth Smith
	Jeanette Trestrail
	Tracy Wilcox
	Vivian Horn
Myers and Stauffer, LC	JoAnn Hicks Chuck Smith Sheryl Pannell

ATTACHMENT II – Letters from Stakeholders

Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

Premier Mental Health, Developmental, and Substance Use Disorder Services in Virginia's Communities

10128 W. Broad Street, Suite B • Glen Allen, VA 23060 • (804) 330-3141 • Fax (804) 330-3611

October 21, 2013

Mr. Bradley Marsh
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Dear Mr. Marsh,

On behalf the Virginia Association of Community Services Boards (VACSB), we offer the following comments on the Draft Report on Audits of Home and Community-Based Services authorized under the 2013-14 Appropriations Act, Item 307 NNNN.

On Page 4 of the document, under the category *reasonable threshold and substantial compliance*, the following is part of the report: **"Stakeholders expressed the opinion that the current documentation requirements being used for audits are too punitive, as a single missing signature or form can invalidate an entire period of care."** The VACSB was one of the stakeholders who brought this issue to the Workgroup, believing that retraction of payment for minor documentation errors when the service was delivered appropriately should not be a punitive measure, particularly when further review of the record provides the evidence needed. We continue to maintain that view. It may be noted that the myriad Medicaid documentation requirements and differences between services that exceed what other insurers require almost guarantee that staff delivering these services will make such minor documentation errors.

However, as the report continues on Pages 4 and 5, the following is written: **"In addition, stakeholders asserted that DMAS should be using a standard of "substantial compliance," which they claim is utilized by Medicare. This standard of "substantial compliance" would allow DMAS to retract only in cases where it appears that the majority of services were not provided, regardless of whether they have met all documentation requirements for those services. Lastly, stakeholders suggested that federal regulations permit DMAS to take only partial retraction for cases."**

The VACSB was not one of the stakeholders interested in pursuing the standard of "substantial compliance" as defined in the paragraph above. At no time during this process or any process has the VACSB ever considered "substantial compliance" as referring to a "majority of services provided" not has the VACSB ever endorsed payment for any services that were not provided. At all times, the VACSB has considered its view of substantial compliance in relationship to documentation of services. Our point has always been that a retraction of funds should not occur for a minor documentation error when there is other documentation that the service has been delivered. For example, the VACSB objects to retraction of payment because of a missing signature, a missing credential, or missing a quarterly review deadline for services that are fully documented and meet all other standards. These are minor documentation issues and other supporting documentation provides the guarantee that the services have been delivered and delivered appropriately.

Once again, the description in the draft of "substantial compliance" seems to deal with "provision of a majority of services". The VACSB issue with substantial compliance has to do with documentation.

This letter should clarify that the VACSB is not among providers who asked for substantial compliance with regards to services provided. Our concern is and has been minor documentation issues that do not have to do with whether the service was provided when other documentation, easily accessed by auditors, demonstrate that the service was in fact provided. Such audit practices are punitive and impact the credibility of the auditors and the audit process itself. Providers should be focused on delivering quality services and properly documenting those services for reimbursement. The audit process should be focused on assuring that such quality services were delivered and documented properly, not used as a way to deny legitimate payment to providers.

There are numerous examples of how this distorts the audit process but the VACSB has cited them on other occasions. We continue to believe that the audit process will improve for providers, auditors, and DMAS if the following measures are taken seriously and become practice: education of contract auditors as to services being reviewed and regulations in place at the time; appropriate notice to CSBs of what auditors want to review including the dates and access to regulations in place as of that time; reasonable methods for extraction of those records from CSB electronic health records; reasonable accommodation for areas where Virginia Code may be in conflict with what auditors are able to require from CSBs; and substantial compliance with regards to minor documentation errors.

Thank you for the opportunity to comment.

Yours truly,

Mary Ann Bergeron, Executive Director

2

vaACCSES
Virginia Association of Community Rehabilitation Programs

October 16, 2013

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 NNNN on behalf of the vaACCSES. My comments will focus on three overall themes/issues.

Provider Training and Self-Audit Tool
Since 2011, we have made repeated suggestions during Audit Methodology workgroup meetings for enhanced audit training and the development and distribution of a self-audit tool for providers. This will help eliminate the subjectivity of interpretation of standards and/or requirements by both providers as well as auditors. Although this issue has been raised several times, it has never been addressed in any of the reports published.

Audit Stratification and Provider Selection
Although the draft report cites a workgroup discussion and defends the current process of how providers are chosen for audits, it does not address specific suggestions made by the workgroup and that deserve further review. We recommend that the audit selection methodology and data mining software used be one that stays abreast of Virginia's changing waiver program goals and does not inadvertently and disproportionately punish providers that may serve waiver recipients with exceptional behavioral and medical needs transitioning from Virginia's Training Centers. The current system will identify these providers as "outliers" subject to increased audits versus their peer providers that do not choose to serve this level of waiver recipient.

Retraction and Substantial Compliance
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. One example includes a situation in which daily case notes and monthly summaries are completed correctly for three months. However, the quarterly review is not in the record. Often, the retraction is made for the entire quarter. Our recommendation made during the workgroup 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 there are three months' worth of data to support obvious service provision.

We look forward to working with you to maintain the quality of services, the integrity of the community provider system, and still abide by the formal Medicaid rules.

Sincerely,

Karen Tefelski

Karen Tefelski, Executive Director

Cc Honorable Marilyn Tavener, Secretary, HHR
Mr. Joe Flores, HHR Subcommittee, Senate Finance Committee
Mr. Louis Ellie, Director, Office of Program Integrity
Mr. Bruce Patterson, President, vaACCSES