



COMMONWEALTH of VIRGINIA  
*Department of Medical Assistance Services*

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December 1, 2015

**MEMORANDUM**

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

The Honorable Charles J. Colgan  
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones  
Chairman, House Appropriations Committee

**FROM:** Cynthia B. Jones

A handwritten signature in black ink that reads "Cynthia B. Jones".

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

The 2015 Appropriation Act, Item 301 PPP, 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

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

# DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

ADMINISTERING MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM IN VIRGINIA



*DMAS' mission is to provide a system of high quality and cost effective health care services to qualifying Virginians and their families.*

The Medicaid program, signed into law by President Lyndon B. Johnson on July 30, 1965, celebrates its 50<sup>th</sup> year in 2015.

Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act that provides health and long-term care coverage for specific groups of Virginians with low incomes. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, meaning Virginia receives \$1 of federal matching funds for every \$1 Virginia spends on Medicaid.

Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.

All states must follow general federal Medicaid guidelines regarding who is covered, but states set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation.



## Report on Audits of Home- and Community-Based Services

**Report Mandate: 2015-16 Appropriations Act, Item 301 PPP** *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.

Audits are conducted by internal DMAS Program Integrity staff from the Provider Review Unit as well as by a contractor, Myers & Stauffer (MSLC.) 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.

Pursuant to budget language, DMAS worked with providers to establish an advisory group of HCBS providers and held meetings in 2011, 2012,

2013 and 2014. 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*, 2012 *Report of the Activities of the DMAS Advisory Group on Audit Methodology for Home- and Community-Based Services*, and the 2013 and 2014 reports titled *Report on Audits of Home- and Community-Based Services*. For this reporting period there were no revisions made to the methodology for home- and community-based utilization and review audits; however, below is a summary of audit and appeal activity.

**Summary of HCBS Audit Activity:**

During FY 2015, DMAS conducted a total of 182 audits of HCBS providers, which represents about 10 percent of providers billing for these services. DMAS looked at a wide variety of HCBS provider types in FY 2015 including ID Waiver (17 audits), Personal Care (41 audits), Respite Care (31 audits), Private Duty Nursing (10 audits), Home Health (11 audits), Hospice (5 audits), Adult Day Healthcare (12 audits), Congregate Living (27 audits), Service Facilitator (28 audits). Audited providers had total billings of more than \$81.5 million during the review period.

These audits examined claims totaling \$38.4 million in billings and identified a total of \$7.2 million in improper payments related to issues such as missing signatures, improperly-maintained records, and incomplete documentation of services rendered. Because of the way that claims are selected, these findings are not representative of the rate of errors across all HCBS payments. The following table gives a breakdown of these statistics for both fiscal years.

**Table 1: Billings of HCBS Providers Audited by DMAS, FY 2015**

	Audits Conducted	Billings by Audited Providers	Billings of Audited Claims	Total Billings in Error
FY 2015	182	\$81,536,833	\$26,540,296	\$7,215,593

In prior years, stakeholders had expressed some concern that the provider selection process resulted in larger providers being targeted while smaller providers were not being audited. The table below shows the breakdown of audits of HCBS providers by the total dollars in claims filed by selected providers during the audit review period. As is evident from this table, providers of all sizes were audited. While providers with \$100,000 to \$1 million in claims are still subject to the greatest number of audits, audits of providers with fewer than \$100,000 in claims still make up a substantial proportion of HCBS provider audits.

**Table 2: HCBS Audits by Provider Billing Volume, FY 2015**

	Total Audits Conducted	Under \$50K in Claims	\$50K-\$100K in Claims	\$100K-\$1M in Claims	over \$1M in Claims
FY 2015	182	48	24	93	17

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## Summary of HCBS Audit Appeal Activity:

Because of the duration of the appeals process, only those audits completed by the end of FY 2014 have reached final resolution, and can therefore represent reliable information on appeals outcomes. Of the 100 HCBS audits conducted in FY 2014, 91 had findings totaling \$4,174,426. Twenty-two of these audits were appealed to the Informal Fact Finding Conference (IFFC) level. Of those 22 appeals, 12 resulted in a reduction of the overpayment findings of the original audit. All of the reductions at IFFC were due to providers producing additional documentation during the appeal. Auditors made \$704,096 in adjustments to the identified overpayments as a result of these documents. After IFFC, the next level of the appeals process is the formal appeal. Seven providers appealed to this level, with a total overpayment amount of \$253,913 being appealed. There were no reductions associated with these seven formal appeals.

**Table 3: Results of IFFC Appeals of FY 2014 HCBS Audits**

	Total Audits Conducted	Audits with Findings	Audits Appealed	Findings Appealed	Audits Reduced at IFFC	Overpayment reduction (IFFC)
FY 2014	100	91	22	\$1,208,233	12	\$704,096

## Conclusion:

Home and Community Based Services (HCBS) are an important part of the Medicaid program. The Department continues to work with our partners to ensure individuals' needs are met while living safely in the community. The Department's goals relative to this mandate are to maintain a collaborative relationship with HCBS providers, to address provider concerns and to improve the audit process while ensuring program integrity. DMAS will continue to conduct reviews to validate that HCBS providers are billing correctly and documenting those billings, but will work to do so in a manner that minimizes unnecessary impact on providers.