COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 1, 2016

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

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

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

2016 Appropriation Act, Item 306 HHH 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

Report to the General Assembly

Audits of Home-and Community Based Services

December 1, 2016

Report Mandate: ***2016 Appropriation Act, Item 306 HHH 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.

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) ensure 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) ensure providers are aware of 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 from prior years, 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*

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, celebrated its 50th 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%, so Virginia receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Medicaid is primarily available to children in families with low-income, pregnant women, elderly, individuals with disabilities, and parents below strict income limits.

DMAS also administers Virginia's Children's Health Insurance Program (CHIP) known as FAMIS. FAMIS covers children and pregnant women in families earning too much to qualify for Medicaid but too little to afford private insurance.

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

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 2016, DMAS conducted a total of 178 audits of HCBS providers. DMAS looked at a wide variety of HCBS provider types in FY 2016 including ID Waiver (15 audits), Personal Care (40 audits), Respite Care (27 audits), Private Duty Nursing (11 audits), Home Health (13 audits), Hospice (6 audits), Adult Day Healthcare (12 audits), Congregate Living (38 audits), Service Facilitator (16 audits). Audited providers had total billings of more than $85.3 million during the review period.

These audits examined claims totaling $27.8 million 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. Claims are selected based on as system that identifies potentially aberrant payments. The claim selection method is not a random statistically valid process therefore; the 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 2016

	Audits Conducted	**Billings by Audited Providers**	**Billings of Audited Claims**	**Total Billings in Error**
FY 2016	178	$85,364,003	$27,789,984	$7,237,839

DMAS reviews error findings to determine if there are policy or regulatory changes needed to reduce errors, or whether additional trainings need to be offered to providers on proper billing practices. If audits indicate substantial improper billings from a provider, DMAS can refer the provider to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for further investigation and potential fraud prosecution. DMAS referred 36 HCBS providers to MFCU as a result of FY 2016 audits.

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 2016

	Total Audits Conducted	**Under $50K in Claims**	**$50K-$100K in Claims**	**$100K-$1M in Claims**	**over $1M in Claims**
FY 2016	178	44	22	94	18

Summary of HCBS Audit Appeal Activity

Because of the duration of the appeals process, only those audits completed by the end of FY 2015 have reached final resolution, and can therefore represent reliable information on appeals outcomes. Of the 182 HCBS audits conducted in FY 2015, 168 had findings. Sixty-seven of these audits were appealed to

the Informal Fact Finding Conference (IFFC) level. Of those 67 appeals, 28 resulted in a reduction of the overpayment findings of the original audit. Auditors made $1,097,556 in adjustments to the identified overpayments as a result of the informal appeals process. After IFFC, the next level of the appeals process is the formal appeal. Eighteen providers completed the formal appeal process, with a total overpayment amount of $2,098,616 being appealed. Formal appeals decisions reduced the overpayment in three of these cases with a total reduction of $252,430.

Table 3: Results of IFFC Appeals of FY 2015 HCBS Audits

	Total Audits Conducted	Audits with Findings	Audits Appealed	Findings Appealed	Audits Reduced at IFFC	Overpayment reduction (IFFC)
FY 2015	182	168	67	$4,872,768	28	$1,097,556

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.