COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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December 1, 2017

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

2017 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

Annual Report: Audits of Home- and Community-Based Services – FY 2017

A Report to the General Assembly

December 1, 2017

Report Mandate:

2017 Appropriation Act, Item 306 HHH 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 an 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, the Family and Individual Support Waiver (FIS), Elderly or Disabled with Consumer Direction (EDCD), the Community Living Waiver (CL), the Building Independence Waiver (BI), and Alzheimer's Assisted Living waivers.

Audits are conducted by internal DMAS Program Integrity staff 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*

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

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.

Summary of FY 2017 HCBS Audit Activity

HCBS providers are audited in a variety of service areas. The table below lists the total number of providers billing in each of these service areas for the claims period audited in FY 2017. It is important to note that individual providers may be counted multiple times if they bill in multiple service areas or under different waivers.

Provider Type	Provider Count for FY 2017 Audit Period
Adult Day Healthcare	51
Congregate Living (ID)	369
Home Health	130
Hospice	78
ID Waiver	697
Private Duty Nursing (PDN)	101
Personal Care	751
Respite Care	670
Service Facilitator	432
Total	**3279**

During FY 2017, DMAS conducted a total of 236 audits of HCBS providers. DMAS looked at a wide variety of HCBS provider types in FY 2017 as shown in the table below

Provider Type	FY 2017 Audits	Billings of Audited Claims	Total Billings in Error
Adult Day Healthcare	15	$360,959	$61,971
Congregate Living (ID)	23	$6,114,702	$513,756
Home Health	16	$297,103	$13,951
Hospice	6	$2,118,635	$409,484
ID Waiver	48	$7,637,023	$922,458
Private Duty Nursing (PDN)	17	$1,662,882	$703,529
Personal Care	47	$7,779,384	$1,105,389
Respite Care	34	$1,219,263	$294,689
Service Facilitator	30	$309,009	$176,865
Total	**236**	**$27,498,959**	**$4,202,095**

Audited providers had total billings of more than $189.7 million during the review period. These audits examined claims totaling $27.5 million and identified a total of $4.2 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.

DMAS reviews error findings to determine if there are policy or regulatory changes needed to reduce errors, or whether trainings need to be offered to providers on proper billing practices. If audits indicate substantial improper billings from a provider, DMAS can report the provider to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for further investigation and potential fraud prosecution. DMAS reported 28 HCBS providers to MFCU as a result of FY 2017 audits.

DMAS Audits HCBS Providers of All Sizes

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.

FY 2017 HCBS Audits	Under $50K in Claims	$50K-$100K in Claims	$100K-$1M in Claims	over $1M in Claims
236	**47**	**31**	**110**	**48**

Summary of Appeals of FY 2016 HCBS Audits

Because of the duration of the appeals process, only those audits completed by the end of FY 2016 have reached final resolution, and can therefore represent reliable information on appeals outcomes. Of the 178 HCBS audits conducted in FY 2016, 58 were appealed to the Informal Fact Finding Conference (IFFC) level. Of those 58 appeals, 31 resulted in a reduction of the overpayment findings of the original audit. Auditors made $489,404 in adjustments to the identified overpayments as a result of the informal appeals process.

FY 2016-Audits	Audits Appealed	Findings Appealed	Overpayment reduction (IFFC)
178	**58**	**$6,756,721**	**$489,404**

After IFFC, the next level of the appeals process is the formal appeal. Twenty-five providers completed the formal appeal process, with a total overpayment amount of $4,811,368 being appealed. Formal appeals decisions reduced the overpayment in two of these cases with a total reduction of $281.

Summary

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 strives 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.