HCB Waiver Service Authorization and Provider Billing Documentation

November 28, 2018

MACS CEO & Leadership Conference | Strategies for Navigating Change
Presented by Wanda Seiler, Senior Director

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<td>Federal and State Regulatory Authority</td>
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Background

Developmental Disabilities Administration’s efforts and A&M’s role
Background of DDA’s Efforts

DDA’s efforts and A&M’s Role

Through the 2018 Community Pathways renewal & implementation of Community Supports and Family Supports Waivers, DDA introduced new services & revisions to existing services - to effectively deliver these services it is imperative that:

- There are clear guidelines for DDA to authorize services
- Providers understand requirements for documentation

A&M worked with state staff and providers to define documentation expectations to:

- Enhance provider understanding of new and revised services
- Develop reasonable expectations for provider documentation
- Mitigate Risk related to Federal and State audits
US HHS OIG Audits

Why service authorization and provider documentation matter
US HHS OIG Audits

Why service authorization and provider documentation matter

• March 2011: Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health

• January 2015: New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State’s Developmental Disabilities Waiver Program

• October 2016: State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program
US HHS OIG Approach

Why service authorization and provider documentation matter

• Reviewed the supporting documentation including individual service plans, monthly staff notes, attendance reports, clinical notes, and other medical history notes
• Verified services were paid accurately based on the individual payment rate sheets provided by the State agency
• Ensured claimed services were included in the approved plan
• Confirmed beneficiary eligibility for services
• Determined whether services were provided by appropriately qualified staff
US HHS OIG Audits – New Mexico


New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health (March 2011)

• Period: 10/1/2006 – 9/30/2008
• Statewide personal care expenditures $433M ($309M Federal Share)
• Ambercare revenue $33M ($24M Federal Share)
• N = 100
• 77 Compliant / 23 Partially compliant
• Improper Claiming = $9,043
• Estimated Improper claiming for Ambercare = $889K Federal Share
Audit Findings – New Mexico

Why service authorization and provider documentation matter

- Personal Care Assistants must have 12 hours of annual training
- Current CPR certification
- Prior Approval from Legal Guardian
- Physician Authorization
US HHS OIG Audits – New York


New York Unallowable Costs for Services by New York State Providers Under the State’s Developmental Disabilities Waiver Program (January 2015)

- Period: Calendar Years 2006 through 2008
- OPWDD Waiver Program Expenditures = $10.5B ($5.4B Federal Share)
- N= 137 Beneficiary Months
- 100 Compliant and 37 noncompliant beneficiary months
- Improper Claiming = $79,328
- Estimated Improper Claiming $77M
Audit Findings – New York

Why service authorization and provider documentation matter

NY OPWDD Regulations

• 1 Unit: Document at least two face-to-face services in 4-6 hours

• ½ Unit: Document at least one face-to-face service in at least 2 hours

• Participant’s response to services must be documented

Documentation Findings

• Full unit billed – only 1 face-to-face service documented

• Face-to-face service not documented / no description of service provided

• Participant’s response to services not documented

• No documentation of the number of service hours
State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program (October 2016) at [https://oig.hhs.gov/oas/reports/region7/71603212.pdf](https://oig.hhs.gov/oas/reports/region7/71603212.pdf)

<table>
<thead>
<tr>
<th>State</th>
<th>Unallowable Room and Board Costs</th>
<th>Other Unallowable and Unsupported Costs</th>
<th>Total</th>
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<tbody>
<tr>
<td>Maryland</td>
<td>$21M</td>
<td>$45M</td>
<td>$66M</td>
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<td>New York</td>
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<tr>
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<tr>
<td>South Carolina</td>
<td>$6M</td>
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<td>$6M</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$91M</strong></td>
<td><strong>$86M</strong></td>
<td><strong>$177M</strong></td>
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Audit Findings – State Agencies

Why service authorization and provider documentation matter

• Individual Service Plan issues
  ➢ No individual service plan
  ➢ Service not authorized or not provided as authorized

• Inadequate documentation of staff qualifications

• Level of need criteria not met for add-on services

• Services billed for people who were not present due to their attendance at other facilities

• Services not adequately documented to demonstrate services were actually provided

• Service Payment Rate issues
  ➢ Unapproved costs were not excluded
  ➢ Payment rates not properly supported and documented
Federal & State Regulatory Authority

Parameters for Service Authorization and Provider Documentation
Regulatory Authority


• Focus on fraud, waste and abuse
• Establish service authorization process
• Establish pre-payment review (i.e. LTSS edits)
• Establish post payment audits
  ➢ Scope / Sampling
  ➢ Frequency
  ➢ Methodology
Regulatory Authority


Federal Regulations
• State Medicaid Manual, Pub.45
• 42 CFR
• 1915(c) Waiver Application Technical Guide
  • I-2d Billing Validation Process
  • I-2e Billings and Claims Record Maintenance Requirements

State Regulations and Policies
• OIG Audits may “look back” to previous 6 years
• Audits must consider authority applicable to time period
Regulatory Authority

Parameters for service authorization

42 CFR 441.301(c)(2)(xii) states:
“...Commensurate with the level of need of the individual, and the scope of services and supports available under the State’s 1915(c) HCBS waiver, the written plan must...Prevent the provision of unnecessary or inappropriate services and supports.”
Regulatory Authority

Parameters for provider documentation

State Medicaid Manual, Publication 45, §2500.2

Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Your supporting documentation includes at a minimum the following:

• Date of service;
• Name of recipient;
• Medicaid identification number,
• Name of provider agency and person providing the service;
• Nature, extent, or units of service; and
• Place of service.

§2497.2 Availability of Documentation

Requires accounting records be supported by appropriate source documentation....and...readily available for audit.
Our Approach

Collaborate to provide clarification
Our Approach

Collaboration to provide clarification

Service Authorization
• Facilitated by A&M
• DDA Subject Matter Experts
  • DDA Leadership
  • DDA Programs Staff
• Regional Office Personnel
• Clinical Staff

Provider Documentation
• Facilitated by A&M
• DDA Leadership
• DDA Subject Matter Experts
• DDA Provider Representatives
• MACS Leadership
Our Approach - Provider Input
Collaboration to provide clarification

<table>
<thead>
<tr>
<th>Organization</th>
<th>Participant</th>
</tr>
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<tbody>
<tr>
<td>ARC of Baltimore</td>
<td>Kathleen Durkin</td>
</tr>
<tr>
<td>ARC of Northern Chesapeake</td>
<td>Shawn Kros</td>
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<tr>
<td>ARC of Southern MD</td>
<td>Terry Long</td>
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<tr>
<td>Chesterwye Center</td>
<td>Debra Langseth</td>
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<tr>
<td>Community Support Services</td>
<td>Susan Ingram</td>
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<tr>
<td>Compass MD</td>
<td>Rick Callahan</td>
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<tr>
<td>Dove Pointe</td>
<td>Chris Parks</td>
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<tr>
<td>Flying Colors of Success</td>
<td>Mike Hardesty</td>
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<tr>
<td>MACS</td>
<td>Lauren Kallins</td>
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<tr>
<td>MACS</td>
<td>Laura Howell</td>
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<tr>
<td>Providence Center</td>
<td>Joan Miller</td>
</tr>
<tr>
<td>Spring Dell Center</td>
<td>Donna Retzlaff</td>
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Documentation Requirements & Standards

Collaboration to provide clarification

Claim Documentation Requirements

• Date of Service
• Participant’s name
• Medicaid ID
• Name of Provider
• Name of Person Providing Service

• Nature, extent or units of service
• Location
• Provider qualifications

Documentation Standards

• Service monitoring notes
• Service communication & coordination
• Quality reviews
Claim Audit vs. Quality Review

Claim Audit

Quality Review
Clarifying Service Monitoring Notes

Service Monitoring Note (aka “Progress Note”)  
- Service monitoring by CCS 
- Ensures the provision of services as authorized in the plan 
- Review documentation, observe service delivery, talk to the participant/guardian, etc. 
- Assesses and documents the presence (or not) of progress 
- Very specific requirements regarding what must be documented 
- Happens well after service provision bill submission - inappropriate requirement for submission of billing/FFP claiming 

Service Note*  
- Used to record information related to service delivery 
- Typically done at the end of service delivery...staff may do this before they leave a shift or a person’s home 
- May include an assessment of progress – but is not required 
- Used to note important information, communicate with team & service providers 
- Used as one of multiple sources of information used in the assessment of “progress” 

*Clarification of LTSS Field for “Progress Note”
Our Approach

Collaboration to provide clarification

Presumption of requirements for FFP claiming (LTSS)
  • Eligible Participant
  • Qualified Provider

Presumption of requirements in §2500.2 (LTSS)
  • Date of service
  • Name of recipient
  • Medicaid identification number
  • Agency / person providing the service
  • Place of service

FOCUS
  • Service Authorization Requirements
  • Provider Billing Documentation - nature, extent, or units of service
The Results

Service specific service authorization and provider documentation requirements
Results – Authorization (General)

Service specific service authorization requirements

• Clarification of service requirements and limits
• Consistent language and expectations regarding the need to exhaust all “appropriate & available services”
• Specification of documentation that must be submitted with a request for service authorization
Results – Documentation (General)

Service specific provider documentation requirements

• Specification of requirements for day services, ensuring billing documentation includes start/end times that occur within a day, clarifying that billing cannot occur for time the participant is absent, for example, to go to a doctor’s appointment

• Clarification for residential and day services that billing documentation must include affirmation the service was provided rather than an assumption the participant is present unless there is information documenting his/her absence
Authorization & Documentation

Requirements for enhanced staffing ratios example: Community Living Group Home

**Service Authorization**
- Documentation requirements
- Service Criteria Clarification
- Examples of what may be authorized
- Specific requirements re: behavioral needs & medical needs
- Time limits

**Provider Documentation**
- Staff time sheets or payroll records with start/end time of staff providing dedicated hours
- For each block of consecutive units of service, document service performed

Dedicated Behavioral Hours
- May use the BP tracking form
Results – Residential Services

Service specific service authorization and provider documentation requirements

Service Authorization
• Specifies criteria for the authorization of residential supports
• Specifies criteria for dedicated hours

Provider Billing Documentation
• Attendance log that documents hours to justify a day rate
• Documented affirmation service was provided
• Adds specific requirements, i.e. requirements for shared living, retainer fee, etc.
Service specific service authorization and provider documentation requirements

Service Authorization
- Must be 18 or no longer in school
- Reflects needs/preferences specified in the PCP
- Specifies service limits
- Specifies required documentation of need
- Specifies other criteria, i.e. fading plan for ongoing job supports when appropriate

Provider Billing Documentation
- Milestone: Requirements are described/specified
- FFS: Staff timesheets with start/end times, dates of service and service note describing tasks relative to the PCP
- Other (monthly): Requirements are specified, i.e. monthly service monitoring note
- Specifies requirements for documenting staffing ratios for group activities
Results – Support Services

Service specific service authorization and provider documentation requirements

Service Authorization

• Exhaust other services
• Reflects needs/preferences specified in the PCP
• Specifies service limits
• Specifies required documentation of need
• Specifies other criteria, i.e. assistive technology cannot be experimental
• Clearly distinguishes between State Plan personal care and personal supports

Provider Billing Documentation

• Specifies requirements for all providers and specific requirements for OHCDS
• Specifies milestone requirements, i.e. Behavioral Assessment
• Specifies requirements for new services, i.e. live in caregiver supports, etc.
• Provides clarity around new nursing services
• Respite Care – specifies requirements by setting
Next Steps

Service specific service authorization and provider documentation requirements

• Office of Health Services and Attorney General Review
• Revisions per OHS and AG review
• Information dissemination and training
• Questions?
References

US HHS OIG Audit Reports


References

CMS Manuals, Technical Guides


• Preventing Medicaid Improper Payments for Personal Care Services booklet at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf

References

CMS Technical Assistance


• Preventing Medicaid Improper Payments for Personal Care Services at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf
