Avoiding Common Payment Errors in Home and Community-Based Services

Introduction

- Centers for Medicare & Medicaid Services (CMS)
- Goal: Reduce payment errors and fraud, waste, and abuse in Medicaid Home and Community-Based Services (HCBS)

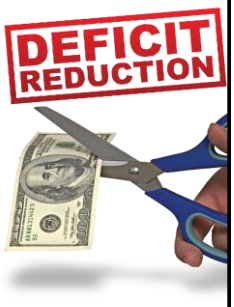
The Medicaid Integrity Program

Legal authority for the Medicaid Integrity Program

- Deficit Reduction Act of 2005
- November 2009 Executive Order 13520—Reducing Improper Payments and Eliminating Waste in Federal Programs

Data sources for errors

- Payment Error Rate Measurement (PERM) program



Common Terms

Single State agency

- The State agency designated to administer or supervise the administration of the State Medicaid plan and determine eligibility for Medicaid

Sister State agency

- A State agency which is responsible for the day-to-day operation of HCBS

Common Terms—Continued

Beneficiary

- Medicaid recipient or his or her representative

Provider

- Anyone authorized to provide Medicaid services, materials, or both to the beneficiary

Person-Centered Plan

- Includes a person-centered plan, plan of care, individual education plan, or service plan

Objectives

After reviewing this presentation, the participant should be able to:

- Identify the role of sister State agencies providing HCBS
- Recall the person-centered plan requirements
- Identify the amount, duration, and scope of authorized services
- Recall the documentation requirements necessary to support a claim

Overview of Medicaid HCBS

Medicaid HCBS eligibility

- People with disabilities
- People who are older
- People with chronic illnesses

Other eligibility considerations

- Financial assessment
- Functional and social needs assessment
- Level of care requirements

Overview of Medicaid HCBS—Continued

Settings for HCBS can include:

- Beneficiary's home
- Assisted living facilities
- Group homes
- Adult day care
- Daytime treatment centers for specific populations

Goal: To allow beneficiaries to live in the most integrated setting.

Overview of Medicaid HCBS—Continued

Basic Services

- Home health care
- Private-duty nursing
- Adult day care
- Durable medical equipment (DME) supplies
- Case management services
- Respite care
- Personal support services

Waiver Programs

- Additional services or units
- Other assistance

How HCBS Are Provided

Medicaid HCBS are provided through:

- Direct contracts with providers
- Managed Long-Term Services and Supports
- Contracts with regional agencies
- Memorandums of Understanding (MOUs) or Inter-agency Agreements with sister State agencies

Sister State Agencies

- Responsible for operation of HCBS
- Receive other Federal funds
- Use their own contractor network
- Provide temporary HCBS

PERM and HCBS

- PERM (Full PERM Cycle 2009–2011)
  https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/FY-2009-2011-Medicaid-improper-Payment-Findings.pdf
- Supplemental measurement data

PERM HCBS Claim Categories

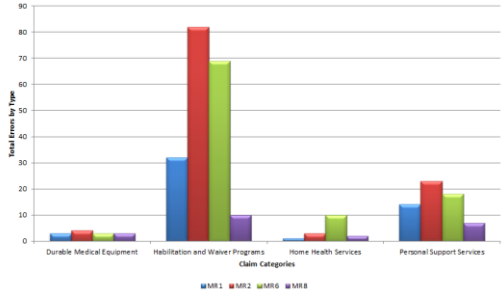
1. DME, supplies, devices, and home modifications
2. Home health services
3. Personal support services
4. Habilitation and waiver programs

PERM Errors

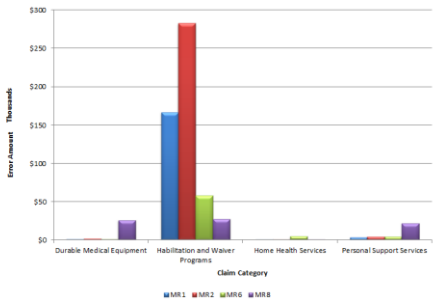
Four types of common errors found

- MR1—No Documentation
- MR2—Insufficient Documentation
- MR6—Number of Units Error
- MR8—Policy Violation

Total Errors by Claim Category



Total Dollars in Error by Claim Category



HCBS Durable Medical Equipment and Home Health Services Common Errors

DME

- Policy violations:
  - Claims not submitted to primary payer
  - Incomplete person-centered plan
  - State-required forms not signed

Home Health Services

- Number of units error:
  - Exceeded amount authorized in the person-centered plan
  - Not calculated correctly

HCBS Personal Support Services Common Errors for Group A States

Policy violations

- Person-centered plans:
  - Incomplete
  - Outdated
  - Missing

Insufficient Documentation

- Service logs incomplete or not signed
- Progress notes missing, incomplete, or not signed
- No attendance records for services in other settings

Habilitation and Waiver Programs

Waiver Programs

- States can design programs that meet the needs of a targeted population
- States can create multiple waiver programs
- States can provide unlimited services
  - Some have a level of care requirement
  - Must be approved by CMS

Habilitation and Waiver Programs—Continued

Waiver Program Services

- Extended attendant aide services
- Home modifications
- Therapeutic services
- Day treatment services
- Computers, mobile devices, and health monitoring equipment
- Transition assistance

Habilitation and Waiver Programs for Group A States

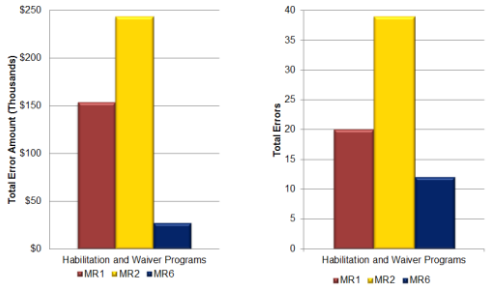
Are provided through agreements with sister State agencies

- Agencies provide and monitor services
- Services are still included in the PERM universe
- Documentation must be provided to support payments
- Communication is critical

Errors and case examples from States

- Sister State agencies are responsible for day-to-day operations

Group A Total Dollars in Error and Total Error Count



Common Errors—No Documentation

Case Example 1 (MR1)

- Expectation:
  - Documentation exists
  - Documentation is provided when requested
- Error: Provider did not respond to request

Promising Practices—No Documentation

Case Example 1 (MR1)

- Create a communication plan
- Designate a point of contact
- Develop a procedure for response
- Provide methods and tools for internal monitoring
- Conduct internal records reviews

Common Errors—Insufficient Documentation

Case Example 2 (MR2)

- Expectation:
  - A person-centered plan is in place
  - Plan must meet requirements
- Error: Provider billed for services not authorized in the plan

Promising Practices—Insufficient Documentation

Case Example 2 (MR2)

- Sister State agency review
- Conduct internal records reviews
- Review each beneficiary's plan
- Keep beneficiary informed of plan services
- SMA oversight

Common Errors—Numbers of Units Error

Case Example 3 (MR6)

- Expectation:
  - Services must be authorized and documented
  - Number of units documented must match claim
  - Units must be calculated according to procedure code
- Error: Number of units documented does not match number of units on the claim

Promising Practices—Number of Units Error

Case Example 3 (MR6)

- Review documentation
- Check calculation of units
- Check for procedure codes

HCBS Person-Centered Plan Expectations

A person-centered plan is individual to the beneficiary and must:

- Indicate diagnosis
- Describe service needs
- Include service needs and goals
- Indicate type and frequency of service
- Indicate level of assistance
- Be reviewed
- Be authorized
- Be current

HCBS Documentation Expectations

Federal guidelines require documentation to support that:

- The beneficiary is eligible
- Services are provided in accordance with the plan
- Services are provided

When claims are submitted there must be:

- Documentation to support the claim
- A complete patient file to support the services

Communication with sister State agencies

HCBS Documentation Expectations—Continued

Promising practices

- Review regulations
- Use calendar to track effective dates
- Hire a coding specialist
- Conduct records review and audits
- States provide oversight

Knowledge Check

What is the role of sister State agencies in providing Medicaid HCBS?

a. Responsible for determining Medicaid eligibility
b. Responsible for day-to-day operations of habilitation and waiver programs
c. Responsible for providing attendant care, housekeeping, grocery shopping, and bathing assistance
d. None of the above

Knowledge Check

A beneficiary's person-centered plan only needs to detail required treatment, not diagnoses.

a. True
b. False

Knowledge Check

A person-centered plan authorizes 14 units of procedure code T2016–habilitation, residential, waiver per diem. The beneficiary is provided 21 units of procedure code T2016. Should the provider bill for the additional 7 units?

a. Yes, the services will be covered even though the number of units was outside the amount, duration, or scope of services authorized in the person-centered plan

b. No, an improper payment will be made if Medicaid funds are used to pay for services outside the amount, duration, or scope of services authorized in the person-centered plan

Knowledge Check

Which of the following is a good practice to document services provided?

a. Review State and Federal regulations to ensure all requirements are tracked

b. Develop a calendar to track effective dates of care plans and when annual reviews need to take place

c. Hire a certified coding specialist to ensure services are coded correctly

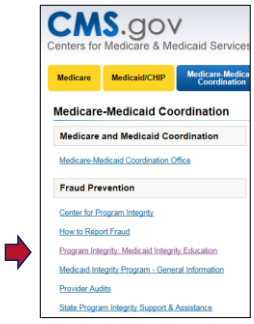
d. All of the above

Walk-Through

Navigate to the CMS website www.cms.gov and click the “Medicare-Medicaid Coordination” tab.

Walk-Through

Under “Fraud Prevention” click the “Program Integrity: Medicaid Integrity Education” link.



Walk-Through

Click on the “Home and Community-Based Services Toolkit” on the menu on the left or in the table on the main page.

Questions

Please direct questions or requests to: MedicaidProviderEducation@cms.hhs.gov

To see the electronic version of this presentation and the other products included in the “Home and Community Based Services” Toolkit, visit the Medicaid Program Integrity Education page at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the Centers for Medicare & Medicaid Services website.

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