



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)

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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



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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 timeliness requirements for response to PERM records requests
- Recall the documentation requirements necessary to support a claim
- Identify where to find the units of service for services provided
- Identify the requirements for maintaining records

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

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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 targeted populations



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

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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



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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

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Sister State Agencies

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

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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 measure

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PERM HCBS Claim Categories

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

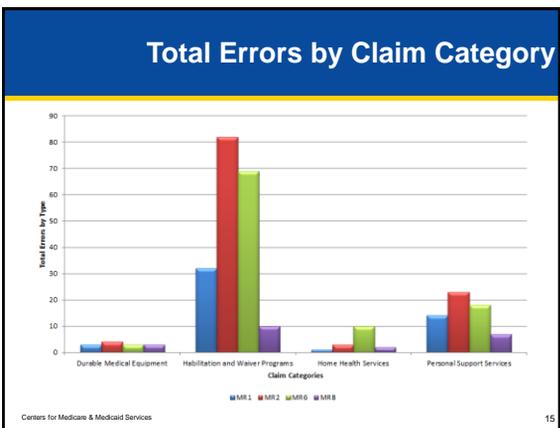
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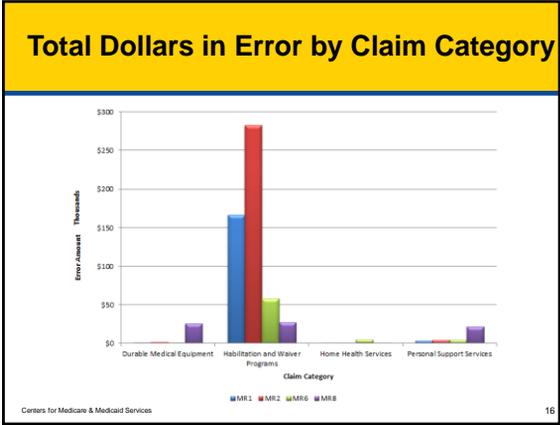
PERM Errors

Four types of common errors found:

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

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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

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HCBS Personal Support Services Common Errors for Group B States

Insufficient Documentation

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

Policy Violations

- Beneficiaries not enrolled in the program during the time span billed

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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

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**Habilitation and Waiver Programs—
Continued**

Waiver Programs

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

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**Habilitation and Waiver Programs for
Group B States**

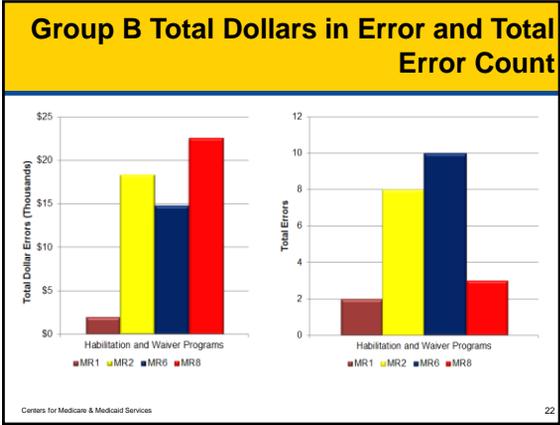
Are provided through agreements with sister State agencies

- 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 both administration and day-to-day operation of HCBS

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Common Errors—No Documentation

Case Example 1 (MR1)

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



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Promising Practices—No Documentation

Case Example 1 (MR1)

- Have a communication plan in place
- Designate a point of contact
- Develop a procedure for response to records requests
- Conduct internal records reviews

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Common Errors— Insufficient Documentation

Case Example 2 (MR2)

- Expectation: For services provided in a location outside the home
 - Documentation should substantiate presence
 - Documentation should show service was provided
- Error: Documentation did not show daily presence

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Promising Practices— Insufficient Documentation

Case Example 2 (MR2)

- Routinely collect daily census from facility
- Create a checklist of documentation necessary to support a claim
- Create a process for quality review of claims
- Perform internal records reviews

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Common Errors— Number 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

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**Promising Practices—
Number of Units Error**

Case Example 3 (MR6)

- SMAs should update MOUs
- Providers should:
 - Review documentation
 - Check calculation of units
 - Check procedure codes

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**Common Errors—
Policy Violation**

Case Example 4 (MR8)

- Expectation:
 - 2 C.F.R. § 200.333 documentation maintained for minimum 3 years
 - SMA requirements may be longer
- Error: Documentation to support claim was destroyed

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**Promising Practices—
Policy Violation**

Case Example 4 (MR8)

- Keep current with Federal and State requirements
- Store documents by date of claim
- Label storage container with the date records can be destroyed
- Double-check records before destroying documents
- Notify SMA if records are destroyed in error

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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



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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
- Documentation must be complete

Communication with sister State agencies

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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

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Knowledge Check

What will happen if a PERM request for documentation to support a claim is not responded to in a timely manner?

- a. The claim will be denied and payment will be recovered
- b. The beneficiary must reimburse Medicaid for the service
- c. The provider may be flagged for receiving an improper payment
- d. Both a and c

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Knowledge Check

Which of the following might be a good quality measure to verify beneficiary presence?

- a. Taking occasional "roll calls" to see if all who have not checked out are still present
- b. Have a receptionist monitor all incoming and outgoing persons through a sign-in/sign-out log
- c. Have visiting providers indicate whom they are seeing when they sign in
- d. Conduct a regular audit to make sure all attendance logs are present in the appropriate physical files or electronic folders
- e. All of the above are good quality measures

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Knowledge Check

The unit of service for each HCBS is identified under the procedure code for the service.

- a. True
- b. False

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Knowledge Check

An in-home waiver services provider serves HCBS beneficiaries in three States. On July 15, 2013, an office manager is going through 2010 records and asks whether to destroy the records. Select the best answer.

- Yes, the year is more than half over and Federal law requires the records be kept for at least 3 years
- No, the records still need to be maintained as Federal law requires the records be kept for at least 3 years from the date of the claim
- Records only need to be kept for a year, so anything with a claim date before 2012 can be destroyed
- Before making a decision, an entity should check with the SMA in the State in which the services were provided

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Walk-Through

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



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Walk-Through

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



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