VNPP 2019 Fall Conference

The Westin Richmond

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Today's Agenda

- HCBS Settings Rule Updates
- EPSDT Updates
- Electronic Visit Verification (EVV)
- Regulations & Manual (CL, FIS, BIW) Updates
- CCC Plus Transition
- Top Findings – QMR
- Meyers & Stauffer Audits

TALKING POINT…

The Home and Community Based Services (HCBS) Setting Rule

What does it mean to be 'A Part of our Community'?

- Remember…the Rule was designed to ensure settings are integrated in and support full access to the greater community.
- Individuals should have opportunities to engage in community life, optimize individual initiative, autonomy, and independence in making life choices.

HCBS Compliance What Providers Want to Know…

HCBS Settings Compliance:
Reviews of provider self assessment Part 1.3 for organizational compliance underway.

<u>Provider Self Assessment - group home, sponsored residential, supported living and group day services:</u>
- <u>123</u> providers met organizational compliance standards.
- <u>202</u> providers demonstrated partial compliance.
- <u>141</u> providers were non-compliant in all areas.

<u>Provider Self Assessment Group Supported Employment Services</u>
- <u>7</u> providers met organizational compliance standards.
- <u>11</u> providers demonstrated partial compliance.
- <u>6</u> providers were non-compliant in all areas.

Providers have been given instructions on remediation needs and resubmission of their Part 1.3 self-assessments. There are Part 1.3 submissions currently in the queue for review. Provider self-assessments represent approximately **<u>3,100</u> <u>settings</u>**.

HCBS Toolkit

The HCBS Toolkit for providers and stakeholders is available on the DMAS website. To learn more visit the Toolkit at http://www.dmas.virginia.gov/#/hcbs

TALKING POINT…

Early Periodic Screening, Diagnostic & Treatment – EPSDT Updates

EPSDT Revisions

- EPSDT changes for children under the age of 21 receiving Developmental Disability Waiver services in the CL and FIS Waivers:
- DMAS - agreement made with the Centers for Medicare and Medicaid (CMS) to reverse policy implemented in November of 2017 regarding the authorization of personal assistance services;
- CMS had instructed Virginia to evaluate personal assistance hours based on criteria from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit-results impacted decisions about the number of personal assistance hours approved for individual members and relied heavily on an assessment of medical necessity;
- **Proposed** revision to EPSDT criteria - as of September 4, 2019, evaluation of personal assistance hours required will be based on criteria outlined in the Community Living (CL) and Family and Individual Supports (FIS) Developmental Disability Waivers.

EPSDT (cont'd)

- Decisions about personal assistance hours will be determined by assessment of the services needed for members to remain in their homes and their communities if they choose that option over institutional care.
- Change will apply only to personal assistance services through the CL and FIS Waivers for members under the age of 21 for service authorization effective date on or after September 4, 2019.
- For members who experienced personal care hour reductions under EPSDT and indicate their needs are not met, proposed guidance will permit the provider to submit a new authorization request to have hours reviewed under the DD Waiver criteria. Reminder: Providers are required to ensure that services are adequate to meet the member's needs.

Update – public comment period is complete – revisions are forthcoming.

TALKING POINT…

Electronic Visit Verification (EVV)

Implementation Dates

The federal 21st Century CURES Act of 2016 requires states to implement Electronic Visit Verification (EVV). Subsequent legislation extended the EVV requirement for Medicaid personal care services to January 1, 2020.

The Virginia Appropriations Act mandates EVV for Companion Care, and Respite Services.

DMAS will require EVV for both Consumer and Agency Directed Services beginning October 1, 2019. That includes: Personal Care Services, Companion Care, and Respite Services.

Home Health will begin on January 1, 2023.

4 Division for Aging and Disability Services

TALKING POINT…

Developmental Disability Waiver Regulations

Update on Regulations for CL, FIS, and BI

3 Waivers; **THE PROCESS**

- **September, 2016** New DD Waivers – through redesign;
  - Emergency Regulations Followed;
- **February, 2019** New Regulations – posted to Town Hall for public comments;
  - 354 Commenters; over 1,600 individual comments and insights reviewed;
- **Current status** –
  - Approved by DMAS, submitted to the OAG for review;
  - Once OAG reviews/approves, submitted to DPB for review/approval, then to HHR and finally, to Governor.
  - Once Governor signs, they are submitted to Register for publication.
  - The regulations will be entered into the VAC 30 days after publication in the Register.

Top 10 Public Comments

1. Align DD & ID Case Management;
   - ID & DD Case Management operates on separate SPAs. DMAS continues to seek avenue for alignment.
2. Recommend removal of DBHDS shall use the SIS® Child for individuals who are five years through 15 years of age. DBHDS shall use the SIS® Adult for individuals who are 16;
   - DMAS revised as requested.
3. Clarification requested concerning prohibiting against the RN billing for supervision of the LPN;
   - DMAS determined most appropriate to add clarification in the manual; not in regulation.

   a) Recommendation to remove requirement for BOTH provider's Plan for Supports AND CMS-485 specific to Private Duty Nursing only;
   - DMAS revised as requested.
4. Request extension from one (1) to two (2) months of Support Coordination for those being D/C from inpatient settings;
   - DMAS revised as requested.
5. Patient pay as Income Related Work Expense (IRWE);
   - DMAS unable to revise. IRWE's are not patient pay expenses.

Top 10 Public Comments, Cont'd

6. Create 'Special Group' category – SSI/SSDI waiver recipients to mitigate impacts from changing household income (e.g., retirement, disability or death) – individual's income increases – placing the recipient over the 300% gross limit;
   - DMAS unable to revise.
7. Suggest changing slot retention back to its previous required 180 days; it is now at 120 days;
   - DMAS unable to revise. Current regulation allows for 150 days.
8. Service Initiation within thirty days – recommend extending to 90 days due to staff training needs, and additional barriers to access services in the 30 day-window;
   - DMAS determined current appeals protocol is sufficient.
9. Delete "to 72" and add "or older" after "years of age" as follows: "DBHDS shall use the SIS Adult for individuals who are 16 to 72 years of age or older. Documentation shall be written on the date of service delivery";
   - DMAS revised as requested.
10. Increase Tech Waiver amount from $3,000 annually to $10,000 multi-year limit;
    - DMAS unable to revise. This would require GA action.

TALKING POINT…

CCC Plus to DD Waiver Transition

Transition – what to remember…

1) When individual is transitioning **from** the CCC Plus Waiver **to** a DD Waiver, DD Waiver services cannot begin earlier than the first day of the month after the month in which CCC Plus Waiver service authorization ends;

Example: if an individual currently enrolled in CCC Plus Waiver is assigned a DD Waiver slot on October 10th, the earliest any DD Waiver service may be authorized to begin is November 1st. The CCC Plus Waiver service authorization must end no later than October 31st.

2) To ensure continuity of care during transition, DMAS and DBHDS plan to implement (possibly effective December 1, 2019) a 30 day continuity of care service authorization for consumer and agency directed personal assistance services;

Service authorization will be approved by DBHDS for number of PA services hours previously approved by the Health Plan for CCC Plus waiver personal care services.

A Medicaid Memo regarding the change will be posted for public comment – will provide guidance on 30 day continuity of care service authorization process and expectation

TALKING POINT…

QMR
Top Review Findings

TOP PROVIDER REVIEW FINDINGS

- ✓ MISSING ***MONTHLY*** LIST OF EXCLUDED INDIVIDUALS & ENTITIES (LEIE) REPORTS;
- ✓ INADEQUATE **OR** MISSING PROGRESS NOTES
- ✓ INADEQUATE QUARTERLY REVIEWS
- ✓ MISSING CORE COMPETENCIES **OR** NO ANNUAL CORE COMPETENCY UPDATES
- ✓ HEALTH & SAFETY NEEDS UNADDRESSED **OR** NOT DOCUMENTED

TALKING POINT…

Myers & Stauffer
General Auditing Services
Annual Report Trends

High-Level Trends Over Five Year Period…

Provider Type	Overpayment Costs
DD Waiver	$1,667,721
Personal Care	$1,020,654
Dentist	$269,262
PDN	$228,170
Respite	$205,688
DRG	$165,223
Svcs Facilitation	$98,334
Physicians	$88,564
Hospice	$59,495
ADHC	$34,063
Home Health	$13,534
EM/AT/PERS	$2,577
Outpt Rehab	$ 422
Intensive Rehab	$ -0-

Under DD Waiver, largest paybacks came from congregate living & group homes

Issues Causing Paybacks Include:

- ✓ Undocumented Services ($1,791,851)
- ✓ Qualified/Trained/Proper Staff Levels ($1,647,215)
- ✓ Criminal Checks ($801,357)
- ✓ Signature Issues ($546,438)
- ✓ Supervision/Initial Visit/Min. Presence ($351,393)
- ✓ Quality of Notes/Missing Info. ($253,723)
- ✓ Plan/POC/ISP/Assessment/Updates ($237,577)
- ✓ Unresponsive to Review Request ($193,452)
- ✓ Admission Documents not Maintained ($143,374)
- ✓ Incorrect Billing Code/Rate/Copay/Diag Code ($122,122)
- ✓ Svc Not Provided in Accordance with POC ($49,267)
- ✓ Medicaid is Payor of Last Resort ($28,807)
- ✓ Notes Conflict/Billed for Missed Visit/Duplicates ($19,236)
- ✓ Family Member is Service Provider/Unpaid ($10,787)
- ✓ Over Authorized/Allowed Amounts ($791)
- ✓ Service not Performed by Reported Provider ($597)

Top 5 Areas to Improve

1. Undocumented Services – billed without supporting doc/number of units billed greater than amt supported by provider doc/no doc supplied at all;
2. Unqualified/Untrained Staff – svcs provided by emp without license/cert, with expired license/cert, or not properly trained;
3. Lack of criminal record checks documented in provider's records or untimely completion;
4. Signature Issues – lack of provider and/or recipient/caregiver signatures; and;
5. Lack of required supervision/initial visit/ min presence notated in provider's records.