Personal Assistance Agency
Fall Provider Conference

November 2017
Welcome

Division of Medicaid, Bureau of Long Term Care staff members:
• Chris Barrott, Alternative Care Coordinator/QA Manager
• Tatiane Schmid, Eastern Regions Quality Improvement Specialist
• Zach Armstrong, Central Regions Quality Improvement Specialist
• Sue Purington, Northern Regions Quality Improvement Specialist
Today’s Training Topics

- Medicaid Program Integrity
  - Lori Stiles, Manager
- Wellness Checks
  - Brian Smith
- Quality Assurance
  - Special Guest – Pete Amador, ABC Homecare
- Service Plan tips and Changes
- Criminal History Timelines and Requirements
- Training Matrix
- Medicare Medicaid Coordinated Plan
- Questions & Answers
BUREAU OF AUDITS AND INVESTIGATIONS

Investigative Units

Welfare Fraud Unit
◦ Client Eligibility (food stamps, cash assistance)
◦ Idaho Child Care Providers (ICCP)

Medicaid Program Integrity (MPI) Unit
◦ Medicaid Providers
Medicaid Program Integrity Unit (MPI Unit)

- **Locations**
  - Boise
    - Manager
    - 1 supervisor
    - 8 analysts
  - Blackfoot
    - 1 supervisor
    - 4 analysts
  - Coeur d’Alene
    - 3 analysts
MPI Unit - Primary Responsibilities

- Conduct Preliminary Investigations
  - Complaints/Referrals/Pro-active
  - Refer credible allegations of fraud to the Medicaid Fraud Control Unit (MFCU)

- Identify Medicaid Overutilization of Services
  - Providers
  - Clients

- Recover overpayments and assess civil monetary penalties

- Make Program/System Recommendations
Date Spanning

- Billing date spans is only allowed when services are provided on every date within the date span.
- It is incorrect to date span the entire week when services were not provided every day of the week.
- It is also incorrect to date span the entire month when services were not provided every day of the month.
- The Medicaid Program Integrity Unit will assess civil monetary penalties for services that are incorrectly billed with date spans.
COMMON AUDIT FINDINGS

- Criminal History Background Checks
- Documentation issues
- Overbilling Units
- Billing Services Not Provided
Recoupment of Overpayments and Civil Monetary Penalties (CMP)
Overpayments

State Medicaid agencies have 1 year from the date of discovery of a provider overpayment to recover or seek to recover the overpayment before the federal share must be refunded to CMS. (42 CFR 433.312)
Civil Monetary Penalties (CMP)

Civil monetary penalties are administrative penalties assessed for the following conduct:

- Submission of incorrect claims
- Submission of fraudulent claims
- Knowingly making false statements
- Billing for services/items known to be medically unnecessary
- Failing to provide immediate access to records
- Failing repeated or substantially to comply with rules and regulations
- Knowingly violating provider agreement
- Failing to repay Medicaid debts
- Fraudulent or abusive conduct
Civil Monetary Penalties (CMP)

- Civil monetary penalties are intended to be remedial, at a minimum recovering costs of investigation and administrative review, and placing the costs associated with non-compliance on the provider.

- Civil monetary penalties are not assessed when a provider self-reports an overpayment and the Department receives the report prior to the initiation of a Department audit.
CMP Percentages

Conduct resulting in no overpayment
- Collecting fees from client when not entitled to collect (10%)
- Minor rule violations (10%) – provided services and services were properly paid but violated rule, policy or provider agreement.
- Significant rule violations (15%) – services were provided but violated rule, policy or provider agreement.

Conduct resulting in overpayment
- Significant rule violations (15%) – services were provided but violated rule, policy or provider agreement.
- Significant rule violations related to client care (20%) – Services were provided but violated rule, policy, or provider agreement related to client care.
- Significant rule violations (25%) for no service or refusal of immediate access to documentation. Services were not provided, were not documented, or provider refused to provide immediate access to documentation upon written request.
Enhanced CMPs

The Department may enhance the penalties if the error rate percentage is greater than 25%.

- Additional 5% penalty - when more than 25% of the audited services are in error
- Additional 10% penalty - when more than 35% of the audited services are in error

The Department may enhance the penalties an additional 15% when the Department determines the conduct was committed fraudulently or knowingly.
CMPs for Criminal History Background Check Violations

The Department may assess CMPs for failing to perform required background checks, failing to meet required time lines for completion of background checks, or using staff who disclosed a disqualifying crime on applications.

- $500 for each month worked for each staff person or contractor without required background check
- Maximum amount assessed per month is $5,000
- Partial months are considered full months for purposes of determining the amount of the penalty
DEBT RECOVERY

Options

◦ Provider adjusts claims
◦ Provider sends lump sum payment
◦ Provider enters into a repayment agreement
  ◦ Typically 12-months or less
◦ Medicaid offsets future payments through Molina
◦ Combination of above actions
Unpaid Debt Recovery

- Payment offset
- Terminate provider agreement
- Referral to collections agency
- Pursue collection through court
Appealing Findings

Administrative Appeals

- All administrative actions can be appealed
- An appeal does not stay the action
- IDAPA 16.05.03.101 – filing of appeals
- At a hearing, providers are given the opportunity to demonstrate to a hearing officer that the Department’s action is not supported by the facts or law.
Self Reporting Overpayments

- Providers are required to refund overpayments to the Department within 60 days of identification (42 USC § 1320a-7k(d))
Self Reporting Overpayments

Provider agreement:

5. Accurate Billing.

.....The Provider shall be solely responsible for the accuracy of claims submitted, and shall *immediately repay* the Department for any items or services the Department or the Provider determines were not properly provided, documented, or claimed.
Idaho Medicaid Program Integrity (MPI) is committed to protecting taxpayer dollars through prevention, detection and the elimination of fraud, waste and abuse in the Idaho Medicaid Program. These efforts help to protect our beneficiaries and ensure Idaho Medicaid has the resources to provide for their care. Health care providers are encouraged to help attain these goals through self-reporting of claim errors or overpayments.

Medicaid providers can refund overpayments by:

- adjusting or reversing claims through the Molina system
- completing an on-line Provider Self-Report Form

Examples of when to self-report:

- Incorrectly coded services
- Services were provided by an unlicensed or excluded individual
- Services were not rendered
- Services are outside the two-year period for adjusting claims

Per federal regulations, providers must report overpayment and return overpayments within 60 days after identified.

Incentives for self-reporting:

- Extended repayment terms
- Waiver of civil monetary penalties
- Quick resolution of overpayments
Compliance

Providers are required to provide services in accordance with all applicable federal laws, statutes, state rules, federal regulations as well as the following.

- Medicaid Provider Handbooks
- Medicaid Newsletters
- Medicaid Information Releases

These documents can be found at:

Report Medicaid Fraud, Waste & Abuse

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- Medicaid Newsletters
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When to Request a Wellness Check
What is a Wellness Check?

▪ I’ve been asked to give a short presentation about welfare checks and when to involve the police.

▪ I am Brian Smith, been with IFPD 13yrs and have been to several CIT trainings and I am a negotiator with the department.

▪ I hope to give all of you a better understanding of when a welfare check is needed, what the police will do once they arrive, and what information you can gather to help those who do arrive to help, IFPD/IFFD.
Many Types of Welfare Checks

- Possible child abuse in the home
- Domestic battery just occurred and one party was yelling for help
- Unsanitary conditions for children in the home
- Threatened or perceived suicidal thoughts/actions
- Behavior that is concerning and out of character and can range from “she posted a suicidal thought to Facebook” to “I just watched him slit his wrist and there was a lot of blood”
Family called from a southern state, meals on wheels noticed nobody had gotten the papers on the porch.
Walked around the house looking for an open door or window.
I didn’t want to break down an expensive door or shatter glass.
I heard a voice from a small bathroom window on the side of the home, I entered thru a man door on the side of the garage.
I found him in the tub where he had fallen 3 days prior. He was trying to use the toilet.
He was cooking breakfast and the stove was still on high and his breakfast was ashes in the pan.
Fire dept arrived and took man to EIRMC and he was able to recover and lived a few more years.
Response

- The police are always the first responders to wellness check situations. Fire will respond to most but stay back until asked to come forward by the police.
  - Depending on the reliability of the information and the severity of the action threatened we have different levels of response.
  - The Facebook post alone would not generally garner a break the door down response.
  - The man who cut his wrists would get a door or window broken and a house full of cops and firemen.
Community Caretaker Search

- There is a designation to the police responding to these types of incidents and it’s called, Community Caretaker Search.
  - Searching a home for a possibly injured person like the story above. Is a good example.
  - In this community caretaker search our primary goal is to check on the well being of someone. We are not gathering evidence etc.
  - We cannot use it as a ruse to get access to a home.
  - We also need to balance the needs of the privacy of the homeowner.
- Sometimes the police can/have been used to harass people.
  - Ex-boyfriend/girlfriend calls and says the other is suicidal.
  - Ex-boyfriend/girlfriend calls to do welfare check on the children staying with the other parent.
When to Call the Police

When should I call the police?

○ If you have reliable information the person is going to cause harm to themselves or another without police intervention.
○ The information is best gathered first hand and not filtered thru emotional family / friends. Sometimes it has to be though.
○ Unless the person has taken steps towards suicide or harming others the police can only talk to them and see if they will admit to suicide planning or we can find evidence showing the planning.
○ If we think the person is a threat to themselves or others due to a mental health issue we can place them into protective custody.
What Happens When They are Taken Away?

- The overwhelming majority of people we place in protective custody go thru the intake process at the hospital and are NOT admitted to a behavior unit.
  - When intake at a facility is done they are free to leave.
  - People under the influence of drugs or alcohol must wait until the effects are gone to be evaluated by BHC. This can take hours.
  - The process can be time consuming and frustrating but like most things medical it’s very deliberate.
Before Calling the Police

● Things to consider prior to calling the police for a welfare check.
  ○ How is the person going to respond to the police?
  ○ Is there information that can help the police prior to their arrival.
  ○ Is there family or friends that can be contacted to try and alleviate the problem.
  ○ Sometimes family and friends can do the job better than other professionals.
Check or Not?

There is no problem erring on the side of safety
“Our doubts assail us and make us fail. And we miss the goal we could achieve only by fear not to reach”

- William Shakespeare -
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QUALITY ASSURANCE
Taking it to the NEXT LEVEL
Quality Assurance
Provider Responsibilities

Medicaid Provider Agreement Additional Terms

The provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules.

A-1.1. The provider conducts a quality assurance program which includes quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. Provider shall implement a quality improvement plan for any deficiencies noted.

A-1.2. **Keep annual evaluation reports** and have them available to IDHW during Quality Assurance reviews.

A.1.3. The provider informs the participant about the participant’s rights, the availability of protection and advocacy services.
For 2018, the BLTC Quality Assurance team will be focusing on meaningful RN oversight of all Aged and Disabled (A&D) Waiver services and Personal Care Services (PCS) delivered by PAAs in the following areas:

- Oversight of participant Progress Notes
- Regular reviews of the participant Service Plan
- Management of the Significant Change process *Note: the Significant Change process must have oversight by the agency RN and the document requires an RN signature
Guest Speaker... Pete Amador
RAISING

Person Centered Service Plans

the BAR
10 Tips for an Awesome Person Centered Service Plan

1. **Ask.** The participant should drive how services are delivered

2. **Listen.** The participant and/or their family are the experts on how they would like their services to be delivered

3. **Embrace.** The participants vision for their service delivery

4. **Ensure.** The plan drives and supports the participants Goals and Outcomes

5. **Identify.** The Risks and Interventions
5. Use **plain language** that the participant and caregiver will clearly understand

6. Make sure the service plan is current – Be flexible to changes if the participants needs, goals or desires change. Add a Service Plan addendum.

7. Ensure that **all services outlined in the UAI** are included in the Service Plan

8. Identify frequency that each service is delivered

9. Identify **WHO** is providing the service

10. **Get it Signed!**
**Goal:** Client wants to lower stress and improve overall health

Service Delivery should support the participants goals

**Preparing Meals** – Client requires assistance preparing low-carb, low salt meals. Client needs soft meals due to dental issues. Client may be able to grab a light snack/drink

**Dressing** – Client can dress himself when he is able to sit down

**Bathing** – Client requires assistance setting up/preparing shower. Make sure water temperature is safe to use and client is able to get in/out of shower. Client prefers privacy during shower.
Beginning January 1, 2018 the Service Plan does not need to be signed by the agency Registered Nurse. It is required that a professional with clinical oversight complete the Service Plan and the Plan must be signed by the Agency Administration. All providers are encouraged to utilize the Bureau of Long Term Care Service Agreement.
What about the Assessment and Plan Development Authorizations?

The Assessment and Plan Development service will continue to be authorized for all participants according to current processes. The requirements for a compliant Service Plan does not vary between programs. The purpose of the service is for an agency RN to assess and evaluate the Service Plan to ensure compliance with the UAI and that it is being properly supported by service delivery documentation.
CRIMINAL HISTORY REQUIREMENTS

Employee must Complete CHU Application

Provider prints the clearance letter from the CHU website within 14 days

Clearance letter must be filed in employee record

Application MUST be Notarized

Provider files notarized application in employee record

Fingerprint appointment completed within the 21 days

Caregiver can only work for 21 days from the notary date
Employees that have had a background check within 3 years

Provider complete background check within 30 days of hire

Form must be printed off from the Idaho State Police

Form must be filed in employee record

ALL employees should have a Criminal History Background check completed and all documentation should be filed in the employee record
Caregiver Training Modules

BLTC has received grant funding and will begin work on Web Based Training Modules in January 2018.

Modules will include:
- General Training
- Attendant Care
- Homemaker
OUR NEW WEBSITE HAS LAUNCHED

http://healthandwelfare.idaho.gov/Medical/Medicaid/LongTermCare/Providers/tabid/3928/Default.aspx
MMCP is getting a new Health Plan

Molina Healthcare of Utah is joining the Medicare Medicaid Coordinated Plan beginning January 1, 2018. Enrollment will begin December 1, 2017!
Contact Information

QUALITY IMPROVEMENT SPECIALISTS

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Additional Resources

BLTC Provider Webpage – all updated forms are available for download
http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeCare/tabid/215/Default.aspx

IDAPA:

Medicaid Newsletters:
https://www.idmedicaid.com/Medicaid%20Newsletters/Forms/All.aspx

Idaho Board of Nursing:
https://ibn.boardsofnursing.org/ibn

Molina Portal “Reference” & “Training” Tabs:

Blue Cross of Idaho (MMCP) - 888-495-2583
www.truebluesnp.com