Building Integrity in Alaska

Detection, Prevention, Prosecution, and Sustainability

Presented by:
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Presentation Topics

- Alaska’s Story
- Collaboration with Partners
- Access and Sustainability
- Informed Policy Decisions
Our Journey

- Personal Care Services - Uncovering Fraud Schemes in Alaska
- Benefits of enrolling Personal Care Assistants (PCA’s)
- Benefits of Collaboration – Getting Results
PCA & HCBW Services in Alaska

- Managed by the Division of Senior and Disabilities Services

- Individual PCA renderers are required to be background checked and enrolled as of July 2010

- Alaska's enrolled rendering provider population increased – no notable access issues
PCA & HCBW Services in Alaska

- Billing occurs through Agency who is certified by Division of Senior and Disabilities Services

- 98% Consumer Directed

- $125,000,000 annual payment FY 2013
Case Development

- Senior and Disabilities Services meeting at Senior Housing raises questions
- Additional allegations were identified
- Preliminary Investigation
- Audit of agency identified high overpayment and error rate
- Search warrant
Good Faith Services, LLC

- Personal Care Assistance and Home and Community Based Waiver Provider (Chore, respite, non-emergency transportation, care coordination)
  - $700,000 in Medicaid Billing in 2009
  - $7,000,000 in Medicaid Billing in 2011

MFCU/PI class and Reid Interview Techniques at Medicaid Integrity Institute

- MFCU/PI class attended by new MFCU Director and Medicaid PI Manager
- Reid interview techniques class attended by SDS QA Manager
Fraud Schemes

- Billing for Services not Provided
  - Out of Country on Date of Service
  - Billing exceeded 24 hours per day
  - Billing for time spans overlapping with other employers
  - Splitting payment with recipient
  - Billing off of service authorization not from timesheet (retroactive billing)
  - Billing while recipient is inpatient
Kickbacks, referral fees and coaching

- Client Managers paid based on volume
- Referral fees paid to new PCAs bringing clients to agencies
- PCA’s splitting payment for services with recipients
- Cash “advances”
- “Coaching” members during assessments to receive unnecessary services
Benefits of Enrolling Rendering Home Care Providers

Visibility into who rendered the service.

Ability to compare and match renderer data to identify:

- Across all agencies and total time worked by a PCA, some work over 24hrs/day
- Cross reference with Background Check data
- Immigration and Customs Enforcement (ICE), service provided while out of country
Benefits of Enrolling Rendering Home Care Providers Continued:

➢ Department of Corrections, providing service while incarcerated

➢ Department of Labor, quarterly wage statements

■ Ability to levy sanctions at the rendering PCA level
  ➢ Credible allegations and payment suspensions
  ➢ Medicaid program suspensions and terminations of individuals
Results

Statistics on PCA and HCBW prosecutions

- 150 Criminal Cases Filed
  - 108 Convictions
  - 4 Corporations
  - 1 physician

- $5,610,228 in Restitution
- $542,800 in Fines
- $85,000,000 PCA spend in FY2015
Lessons Learned

- Work with partnering agencies on pending actions to ensure continuation of necessary services or a balanced approach to closures.
- Inform other agencies (APS, Licensing, OCS, etc) of pending actions.
- Pay more attention to collusion schemes; program staff (assessors, nurses, case managers) are often the first reporters.
- Encourage timely reporting of fraud, waste and abuse.
Working Together

- Adult Protective Services
- Office of Children Services
- Waiver and PCS Program Staff
- Medicaid Fraud Control Unit
- Program Integrity
- Homeland Security
- Law Enforcement
- Licensing
- Legal Staff
- Human Trafficking Committee
- Office of Inspector General
- Federal Bureau of Investigation
Informing Policy

✓ Use real examples to change policy
✓ Don’t focus on outliers; build policy from trends
✓ Goal should be to have clear and precise language that promotes access yet prevents fraud, waste and abuse of program.
✓ Involve the right people at the right time
  o Program Integrity
  o Medicaid Fraud Control Unit
  o Stakeholders – Internal and External
Telling The Story

• Tell the ‘numbers’ people about the people
  ❖ Program Integrity and Data Analytics folks tend to get mired in the numbers; they need to hear about the needs of people behind the statistics.

• Tell the ‘people’ people about the numbers
  ❖ Program Staff and Policy folks tend to focus on access and need, but think of Program Integrity as someone else’s job. Both need to be considered for a sustainable program.

• Tell the Legislature about both the people and the numbers
  ❖ Use real examples if cases are closed and public information
  ❖ Show results of prosecution; general deterrents; quality initiatives
  ❖ Demonstrate good collaboration between agencies
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Program Integrity in Massachusetts Medicaid
Managing Home Health Program Growth

Kerri Ikenberry, RN, BSN, Director of Clinical Services
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Almas Dossa, Assistant Director of Fee for Service Programs
Office of Long Term Services and Supports
Office of Elder Affairs
Massachusetts Executive Office of Health and Human Services
Goals

01. Explore factors leading to provider compliance and PA initiatives
02. Review implementation steps
03. Share lessons learned
04. Discuss impact on community services and other LTSS
05. Review best practices for successful home health program
06. Identify trends
Home Health Care in the USA

80% For-Profit Ownership

20% Not-For-Profit Ownership

# of patients
4.9 million
2013
National Spending on Home Health Care

- 2013: $88.8 billion
- 2014: $88.8 billion + 4.5% = $92.8 billion
- 2015: $92.8 billion + 6.3% = $98.5 billion

Increase in Medicare: 2.6%
Increase in Medicaid: 6%
 Faster growth in private health insurance and out-of-pocket spending
Who’s Receiving Home Health Care?

Percentage of beneficiaries using home health care, by characteristic, 2010

OIG analyzed Medicare claims to assess
“the national prevalence of selected characteristics found in OIG - investigated home health fraud cases.”

Findings:
1. Identified HHAs and supervising physicians that were statistical outliers
2. Identified geographic hotspots

https://oig.hhs.gov/oei/reports/oei-05-16-00031.asp
Home Health Fraud: Geographic Hotspots

Source: https://oig.hhs.gov/oei/reports/oei-05-16-00031.asp
Home Health Fraud: OIG Study Findings and Conclusions

500 HHAs  4,500 physicians
Outliers in comparison to peers

27 hotspots in 12 states

Home health fraud in Medicare continues to require ongoing scrutiny and attention

Past OIG and CMS efforts have been successful in reducing HH spending

Source: https://oig.hhs.gov/oei/reports/oei-05-16-00031.asp
Home Health in Massachusetts

MassHealth provides coverage for:

- Home Health services including Skilled Nursing Visits (SNV)
- Home Health Aide (HH Aide)
- Continuous Skilled Nursing (CSN)
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

No Prior Authorization for SNV nor HH Aide until 2016
Previously, MassHealth did not have a robust program integrity process for auditing home health agencies.

MassHealth relied on audits through Recovery Adult Contractors (RAC).
Working closely with the University of Massachusetts Medical School (UMass), MassHealth implemented:

1. Provider Compliance Initiative
2. Prior Authorization for Home Health services
3. A moratorium on home health enrollment

Program Integrity Changes

2015
Intensified program integrity efforts to control unsustainable expansion of LTSS

- 34,000 members
- 195 agencies
- 2015 $500 million/yr
- 2016 projected $750 million/yr
Starting Point

- Audits
- Prior Authorization & Implementation
- Provider Education & Outreach
- New Home Health Agency Moratorium
Home Health Onsite Audits

19 HHA were selected for audits:

✓ Onsite visits:
  ☑ Record review to ensure compliance with Home Health program regulations and billing regulations
  ✓ Home visits to Members receiving Home Health services
  ✓ Accompanied by CMS for some HH audits
Non-compliance

All HHA audited demonstrated a lack of compliance with the Home Health Provider Regulations

Billing for services not provided

- Member away from home per RN note, but HH Aide services billed for those dates
- Receiving adult day health (ADH) services at same time as service
- Billed for more units of service than provided per HH Aide note
- Billed for a service, but no note/timesheet to back up
- Billed for more units of service than authorized by MD
# Home Health Audits

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Services provided to a person who was not a MH member on the date of service</th>
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<tbody>
<tr>
<td></td>
<td>Billing when member was inpatient</td>
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<tr>
<td>Documentation</td>
<td>Cloned documentation from other member records</td>
</tr>
<tr>
<td>Medication</td>
<td>Expired medications noted from on-site member visit (quality and safety issue)</td>
</tr>
<tr>
<td></td>
<td>Providing medication not authorized by MD</td>
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<tr>
<td>Double billing</td>
<td>Same provider billing for nursing/HH Aide services in different locations/same times</td>
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</tbody>
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Medical Necessity not established

Examples:

“Per OASIS, member independent with all Activities of Daily Living, i.e. walking/stairs/dressing (needs intermittent assistance with shower/bath)”

“Alert and oriented”

“Member has 2 adult children living with her”

“HH services received:
• 3-4 hours of HH Aide 5 days per week
• 5-7 SNV per week (medication reminders/assessment/education)”
Audit Response

1. Sanctions & Recoupments
2. Payment suspensions & HHA closures
3. Attorney General Referrals & Investigations

Improper billing varied between $78,000 - $8.7 million
All providers are appealing
Implementation of Prior Authorization

MassHealth and UMass expanded UMass scope to include PA for Home Health services

- Regulation revisions & promulgation
- Stakeholder engagement
- Submission Criteria identification Form development
- Clinical guidelines development
- Recruitment & development of Home Health PA reviewers
Home Health Prior Authorization Volume

March 2016 – April 2017
Home Health Prior Authorization

- Home Health used to fill gaps in Behavioral Health Services
- Medication Administration
- Family members paid to provide services
- Members receiving SNV’s twice a day and HH Aide 8-24 hours per day
- Children with behavioral health and/or physical disabilities receiving 35-40+ hours/week of HH Aide
- Members receiving SNV and HH Aide services for 5+ years
- Members receiving services from 2 or more home health providers at the same time
- Clinical documentation demonstrating the member did not want the service, but the provider forced them to accept it
- Members not given an opportunity to succeed without home health services
Modifiers on PA coding ensure reduced rate was used after 60 days of HH

HH providers, inappropriately used or didn’t use any modifiers when billing, as required per regulations

PA wrapped modifiers into the PA requirement, locking providers into appropriate billing
Home Health Prior Authorization
Overarching Trends

HHA business models built around behavioral health population

HHA lacked knowledge and understanding of their responsibility to comply with MassHealth regulations

Medication administration was utilized to justify the need for daily to twice a day SNV’s
PA Reviewers Focus on Access to Services

Met regularly to review difficult and challenging cases

Ability to err on the side of the member in decision making

In rare cases decisions were deferred until information was available or services were authorized for a short period of time

Goal: Ensure those who need services, received them
Responding to Trends - Provider Education and Outreach

- Engagement with local home health trade organization
- Robust stakeholder engagement
- Initial webinar held shortly after PA implementation with most agencies attending
- Monthly, regional home health forums that continue today
- Blast email updates as needed
- Each forum allowed for question and answer sessions, as well as covering pressing topics and trends
Community Service/Other LTSS Impacts

• Group home and medication administration visits
  – Collaboration with Department of Mental Health, Department of Children and Families and the Department of Developmental Services helped enforce existing medication administration programs

• Increase in referrals to personal care programs such as PCA and AFC as a more appropriate service for people with ADL support needs with skilled need

• Fair Hearings - Volumes
One Year Later: Cost Savings Comparisons

H - HOME HEALTH AND COMMUNITY HEALTH

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Expenditures</th>
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</thead>
<tbody>
<tr>
<td>SFY 2014</td>
<td>$329,730,294.77</td>
</tr>
<tr>
<td>SFY 2015</td>
<td>$496,892,811.97</td>
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<tr>
<td>SFY 2016</td>
<td>$672,399,790.72</td>
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<tr>
<td>SFY 2017</td>
<td>$515,879,160.56</td>
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One Year Later: Cost Savings Comparisons

HOME HEALTH AND COMMUNITY HEALTH PT-60

Expenditures

- $0.00
- $10,000,000.00
- $20,000,000.00
- $30,000,000.00
- $40,000,000.00
- $50,000,000.00
- $60,000,000.00
- $70,000,000.00

Custom Subset 4 $58,418, $55,702, $57,978, $53,917, $54,035, $53,797, $49,698, $49,749, $47,408, $45,678, $41,350, $36,076, $40,771, $37,563,
Lessons Learned

Stakeholder engagement:
• Provider education on PA process & regulation changes
• Other state agencies

Activities to ensure provider compliance issues identified are addressed

Fair Hearing Preparedness