January 16, 2018

Performance Audit Recommendations and Corrective Actions for Audit: 14-5

DESIGNATED AGENCIES

State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread

Dated: 10/14/2014

Overview

The SAO makes recommendations designed to improve the operations of state government. For our work to produce benefits, auditees or the General Assembly must implement these recommendations, although we cannot require them to do so. Nevertheless, a measure of the quality and persuasiveness of our performance audits is the extent to which these recommendations are accepted and acted upon. The greater the number of recommendations that are implemented, the more benefit will be derived from our audit work.

In 2010, the SAO began to follow-up on the recommendations issued in our performance audits. Experience has shown that it takes time for some recommendations to be implemented. For this reason, we perform our follow- up activities one and three years after the calendar year in which the audit report is issued. Our annual performance reports summarize whether we are meeting our recommendation implementation targets. (http://auditor.vermont.gov/about-us/strategic-plans-and-performance-reports)

This report addresses the requirements of Act 155 (2012) to post the results of our recommendation follow-up work on our website. The report does not include follow-up on recommendations issued as part of the state's financial statement audit and the federally mandated Single Audit, which are performed by a contractor. However, our current contract for this work requires the contractor to provide the results of its recommendation follow-up.

Audit Number & Name	Rec #	Recommendation	Follow-Up Date	Status	Review Comments
14-5 Designated Agencies (DA): State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread	DAIL-1	Department of Disabilities, Aging, & Independent Living (DAIL) - Develop a mechanism to determine the extent to which clients are receiving services, including the number, types, and frequency, for which the DAIL is paying an inclusive rate to the Designated Agencies (DAs).	2015	Partially Implemented	DAIL held meetings with the developmental services agencies to reinforce the need for transparency and accountability for the use of funds. DAIL updated the developmental disability services (DDS) spreadsheet manual on July 1, 2015 which provides DAs with more specific instructions for maintaining up to date information on monthly spreadsheets that are submitted for approval of individual plans of care. DAIL is currently participating in the development of a new Medicaid Management Information System (MMIS) to facilitate the reconciliation of payments with services delivered.
			2017	Implemented	The Director of Developmental Disabilities Services Division (DDSD) reported DAIL continues to conduct comparisons of individual support agreements (ISA's) and services through the DDSD Quality Services Review process as well as a bi-annual review process for high cost consumers. According to the Director, DAIL Quality Management Team currently reviews 10% - 15% of ISA's per DA every two years, compares services received, and offers feedback to the DAs on the quality of the ISA. Future audits by DAIL will include review of ISA's and comparisons to both electronic health records and claims to ensure that the ISA's include all funded service areas. Furthermore, DAIL has developed annual audit procedures as part of the Medicaid Manual update, effective 12/1/2017, which will require the review of the ISA's to determine that the payments for services are included in a current approved ISA.
	DAIL-2	Except for developmental disability home and community based services, develop a process to perform periodic detailed confirmation, on at least a sample basis, that the amount approved equals the amount the DAs billed for services that are coded as pay as billed in the MMIS.	2015	Partially Implemented	DAIL provided a copy of procedures, drafted in December 2015, to monitor developmental disability claims for those paid as billed claims (except developmental disability home and community based services). The confirmation process will include running quarterly MMIS claim reports for the Bridges Program, Specialized Services, and Family Managed Respite. The Developmental Disability Services Division (DDSD) staff will compare the actual rates billed against the DDSD approved rate on file. The actual review of the MMIS claim reports has not been implemented but is targeted to begin in April 2016.
			2017	Implemented	DAIL reported that a new process has been implemented for pay-as-billed reviews. DAIL provided a copy of a recent quarterly review. The process includes reviewing claims that are inconsistent with the authorized rate and service duration on file. After reviewing these claims, the Senior Auditor/Program Consultant will contact the DAs to inform them of the erroneous claim billing and request recoupment and rebilling if the rate exceeds the approved amount.
	DAIL-3	Update its DA provider manual related to developmental disability programs to reflect current practices. In the interim, written communication should be expeditiously sent to the DAs to specify the number of units that can be charged for 15 minutes of developmental disability (DD) targeted case management (TCM) services.	2015	Partially Implemented	DAIL issued a memo to the DAs on November 25, 2015 clarifying the correct billing units for DD targeted case management services. The DD Provider Manual is scheduled for completion by July 1, 2016.
			2017	Implemented	DAIL provided a copy of the updated Medicaid Manual for Developmental Disabilities Services effective 11/13/2017. The updated manual now includes a clarifications for billing units for TCM billing rules.

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14-5 Designated Agencies (DA): State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread	DAIL-4	Request and help develop an error status code that prevents developmental disability home and community based services or developmental disability TCM claims from being paid when a client is in a nursing home.	2015	Partially Implemented	DAIL submitted a request to the HP Enterprise Services, LLC. on December 9, 2015 for an error status code to be put in place to prevent developmental disability home and community based services or developmental disability targeted case management claims from being paid when a client is in a nursing home.
			2017	Partially Implemented	DAIL reported that they are working through a contract with the Medicaid billing agent, DXC, to develop error status codes to prevent developmental disability home and community based services (HCBS) or developmental disability TCM from being paid when a client is in a nursing home. DAIL is collecting additional information to determine the cost effectiveness of doing this work since the contract with DXC only allows for a certain number of hours to complete this work. In the interim, DAIL has identified a remedy but it must be done manually. TCM and HCBS billings are reviewed to verify the amount accurately reflects discharge planning and to ensure it is not double billed. For example, if a nursing home claim arrives at DXC after an HCBS claim for same date has been paid, the system will pay the nursing home claim and DXC will run a monthly report to identify double billing and recoup funds from agencies who are erroneously billing for HCBS.
	DAIL-5	Periodically review the error status codes that pertain to DAIL programs including, at a minimum, immediately after the planned revision to the DD Provider Manual is completed.	2015	Not Implemented	According to DAIL, this recommendation will be completed after the revision of the DD Provider Manual which is scheduled for completion on July 1, 2016.
			2017	Partially Implemented	DAIL reported that a master list of all DAIL DDSD billing codes has been generated and allowable billing combinations have been identified along with prohibited billing. DAIL is working with DXC to verify limitation audits are in place for each restricted billing combination. DAIL plans on conducting annual reviews of error status codes (ESC's) to ensure that changes during the year have been updated in the MMIS.
	DAIL-6	Include as part of the re-designation review/quality management reviews, procedures that check whether DA DD claims meet DAIL billing requirements and billing limitations, and whether claim documentation meets DAIL standards and seek reimbursement, as appropriate.	2015	Partially Implemented	DAIL reported that a Financial Manager was hired on May 17, 2015. One of the responsibities will be to perform financial audit reviews. DAIL is currently developing a financial audit process which includes reviews of agency billing and obtaining reimbursements, when appropriate.
			2017	Partially Implemented	DAIL's Director of Development Disability Services (DDS) reported as part of the re-designation process, DAIL's DDSA Financial Manager will begin providing results of paid claims and service data audits to the Quality Management Team for incorporation into the Quality Services Reviews and Re-Designation Reviews.
	DMH-1	Develop a mechanism to determine the extent to which clients are receiving services, including the number, types, and frequency, for which the Department of Mental Health (DMH) is paying an inclusive rate to the DAs. For example, this mechanism could entail developing a system that tracks actual services against individuals' service plans or requiring DAs to periodically submit comparison data to DMH.	2015	Not Implemented	Per DMH, the department is working with Berry Dunn, Pacific Health Policy Group (PHPG) and Burns & Associates to understand the current systems in place and what automation for query and reporting can be developed within the new MMIS capacity. The timeframe for completion will parallel the MMIS implementation.
			2017	Not Implemented	DMH reported this recommendation has not been implemented because the development of a new MMIS has been put on hold by AHS. According to DMH, without the IT infrastructure that was planned as part of the MMIS project, implementing this recommendation would entail a highly manual and inefficient process and be cost prohibitive considering DMH's limited staff and resources.

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14-5 Designated Agencies (DA): State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread	DMH-2	Develop a list of services that each Private Non-Medical Institution (PNMI) can and cannot bill and evaluate whether an MMIS ESC can be implemented to prevent DAs from charging for similar services already provided by these institutions.	2015	Partially Implemented	The Director of Rate Setting, from the Agency of Human Service's Division of Rate Setting, sent memos to all designated agencies on February 9, 2015 identifying which services are and are not included in the PNMI rate and which can be billed concurrently. However, DMH has not evaluated whether a MMIS ESC can be implemented to prevent DAs from charging for similar services already provided by these institutions.
			2017	Partially Implemented	DMH has developed a list of PNMI services which can and cannot be billed and recently conducted feasibility studies to determine whether the implementation of PNMI ESC's are feasible. However, it was determined that implementing ESC's would be cost prohibitive.
	DMH-3	Issue instructions to the DAs specifying under what circumstances a DA can bill for services performed on the same day for the same client in 15-minute increments and about whether or to what extent the DA that provides services to a client for whom a different DA receives an inclusive rate can bill Medicaid for those services.	2015	Partially Implemented	The latest DMH Medicaid manual, revised on July 1, 2014, requires that DAs aggregate the time spent on certain services so that it does not exceed the actual time provided to an individual on the same day. However, this manual does not explicitly address billing when one DA provides services to a client that receives an inclusive rate service from another DA.
			2017	Implemented	DMH reported the Fee-For-Service Provider Manual has been updated in the current version dated 7/1/2014 to establish clear billing and documentation standards.
	DMH-4	Review the ESCs that pertain to DMH programs and ensure that they are up to date in light of the new DMH Fee-for-service provider manual and, in the future, periodically review the ESCs to ensure that they remain current.	2015	Not Implemented	DMH reported that it created a Senior Auditor/Program Consultant position that will be responsible for this task. The position is currently being reviewed by the Department of Human Resources. Once this position is filled, DMH plans on developing a process to review all ESC's and integrating the results of these reviews into the designated agency reviews.
			2017	Partially Implemented	DMH reported their Senior Auditor and Department of Vermont Health Access' (DVHA) Program Integrity MMIS Compliance Specialist are working together to identify and review/update all current DMH related ESCs and add additional ones as needed. This review is being done to ensure that ESCs are still valid and performing their function effectively.
	DMH-5	Include as part of the redesignation review/quality management reviews, procedures that check whether DA mental health claims meet DMH billing requirements and billing limitations, and whether claim documentation meets DMH standards and seek reimbursement, as appropriate.	2015	Not Implemented	DMH reported that it created a Senior Auditor/Program Consultant position that will be responsible for this task. The position is currently being reviewed by the Department of Human Resources. Once this position is filled, DMH plans on developing a process to review all ESC's and integrating the results of these reviews into the designated agency reviews.
			2017	Partially Implemented	DMH stated a Senior Auditor was hired in December 2015 to oversee all program reimbursement reviews, including verification of Medicaid billed claims and reviews of clinical documentation for services provided. Long-term goals include obtaining audit results from DVHA in a timely manner for the Payment Error Rate Measurement Program (PERM) conducted every three years by the Centers for Medicare & Medicaid Services to support it's recoupment efforts of improper payments to providers. In the interim, the DMH Senior Auditor is querying claims data to ensure compliance with DMH policies and Medicaid requirements. DMH provided an example of a recent provider claim for interpreter services which were incorrectly billed to and paid by DMH. DMH was able to recoup $4,840 from this provider.