Medicaid and Managed Care Presentation

Home Health Care Overview

Helpful Hints for a Compliant Medicaid Practice

February 4, 2016

Today's Goals

Provide a better understanding of:

- the State Agency and MCO structure;
- the Medicaid Regulatory Framework;
- Medicaid documentation requirements;
- Third Party Liability (TPL) requirements;
- Fraud, waste & abuse obligations;
- Consequences for non-compliance; and
- Your obligations as a home health care provider.

Medicaid is a voluntary program.

Participants must know, accept and abide by the rules and regulations.

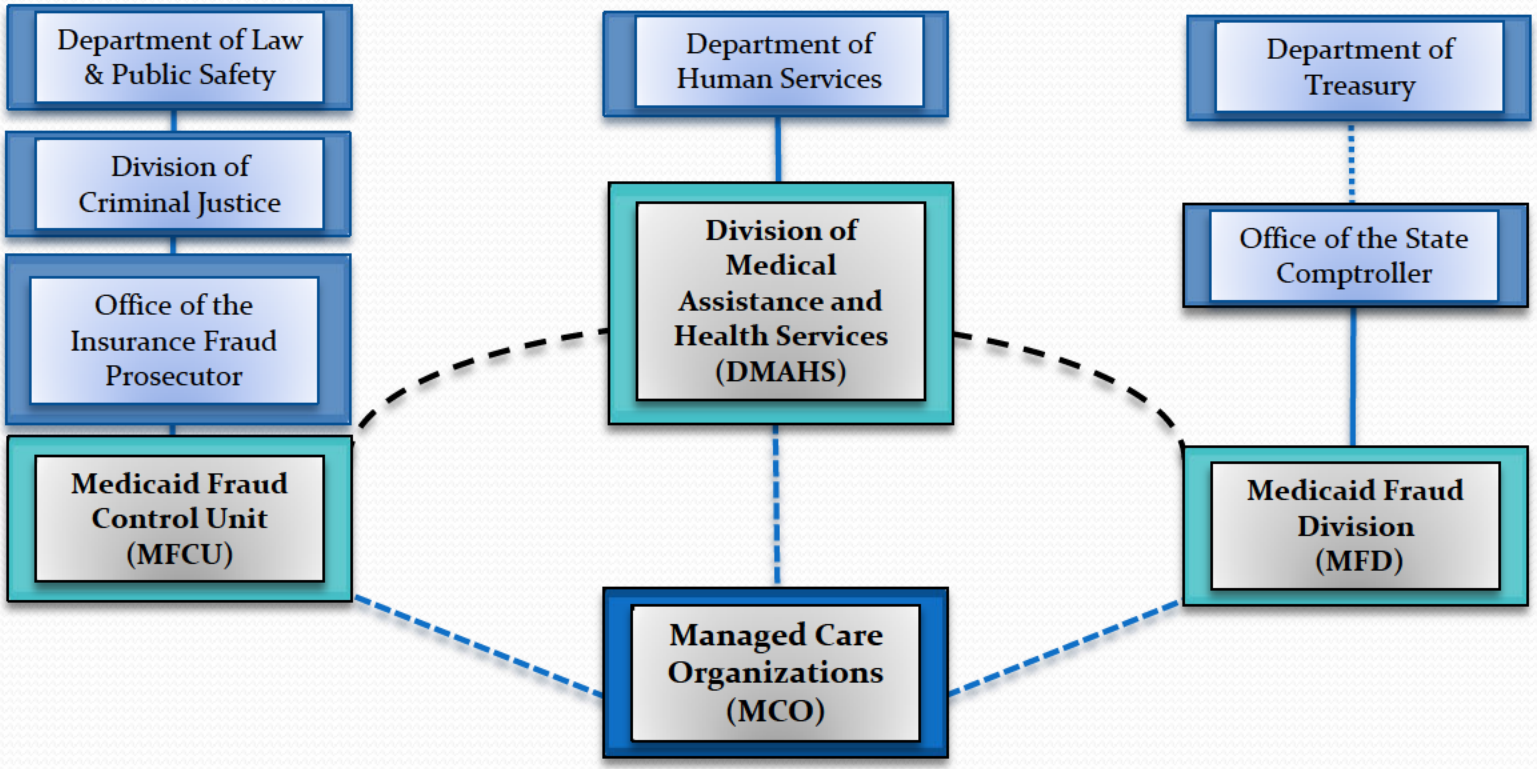
Medicaid

- Medicaid is a joint Federal and State program that helps with medical costs for some people with limited income and. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services.

- Individuals who qualify for both Medicare and Medicaid are referred to as “dual eligibles.”

Administration & Oversight

New Jersey's Medicaid program is administered and/or overseen by:



Medicaid Managed Care Contract

The New Jersey Department of Medical Assistance and Health Services has a contract with the following MCOs:

- Aetna Better Health of New Jersey
- Amerigroup New Jersey, Inc.
- Horizon NJ Health
- UnitedHealthcare Community Plan
- WellCare Health Plans of NJ, Inc.

Fraud, Waste & Abuse

Fraud

- An intentional deception, misrepresentation, false statement or false representation of material facts with the knowledge that the deception could result in unauthorized benefit or payment to himself or another person.

- Insurance Fraud – *N.J.S.A. 2C:21-4.6*

More Fraud, Waste & Abuse

Waste

- An overuse of healthcare services, or other healthcare practices, that result in unnecessary costs. In most cases, waste is caused by the misuse of resources, not by reckless actions.

More Fraud, Waste & Abuse

Abuse

- Practices that, while not generally considered fraudulent, and which do not involve knowing misrepresentations of facts, are inconsistent with accepted and sound medical , fiscal or business practice.

- Abuse may result in unnecessary costs to a health insurance program, improper payment or payment for services that fail to meet professional standards of care or are medically unnecessary.

MCO Specific Requirements

MCOs may have their own unique requirements. This includes:

- Medical policies (i.e., prior authorizations)
- Reimbursement policies
- Claims submission processes

When in doubt, consult your MCO-specific resources including:

- Provider contract
- Provider manual
- Provider portal
- Provider representative
- MCO website
- Newsletters and provider alerts

IT IS YOUR RESPONSIBILITY TO KNOW THESE REQUIREMENTS.

Medicaid Insurance Fraud is a Serious Crime

- The MFCU in the Office of the Insurance Fraud Prosecutor (OIFP) investigates and prosecutes Medicaid Fraud.
- The MFCU uses attorneys, investigators, nurses, auditors and other support staff to police the Medicaid system.

Medicaid Fraud – N.J.S.A. 30:4D-17

- It's illegal to knowingly and willfully make or cause to be made any false statement in a claim.
- It's illegal to overbill Medicaid for services.
- It's illegal to participate in a scheme to offer or receive kickbacks, rebates or bribes in connection with the furnishing of items or services that are billable to Medicaid.

Medicaid Fraud Consequences

- Punishable by up to 5 years in state prison
- Mandatory penalty up to $25,000 for each violation
- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Suspension or loss of professional licenses
- Restitution/Recovery of overpayments

Health Care Claims Fraud - N.J.S.A. 2C:21-4.3

- It's illegal to submit a claim to the Medicaid program or an insurance company for health care services that were not received or provided.
- Punishable by up to 10 years in state prison.
- Violators may be subject to a fine up to five times the amount of their false claims.
- Suspension or debarment from government funded healthcare programs.
- Forfeiture of professional license.

Whistleblower/Qui Tam

- Empowers people to file civil suit against individuals and companies that defraud the federal, state or local government.
- Whistleblowers may be eligible for up to a 30% share of the recovery.
- Whistleblowers may be protected from being fired or retaliated against by their employer for reporting fraud and abuse to authorities.

Did you know…

- Practitioners who hold a professional license can be convicted for submitting a single false claim.
- Willful ignorance of the truth or falsity of a claim is not a defense.
- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.
- In addition to fraud, the MFCU investigates and prosecutes patient abuse and neglect and financial exploitation.

Limited, Moderate and High Risk Categories

Assigned by CMS

HOME CARE PROVIDER RISK: HIGH

- High Dollars Spent
- High Risk for Fraud, Waste and Abuse
- High Conviction Rates - 30% nationally
- Monetary Recoveries - $1.7 Billion nationally
- Large volume of exclusions

Medicaid Payments for Home Care Services

Fiscal Year	2013	2014	2015	Total
Encounters	$381,157,088	$357,443,881	$565,312,292	$1,303,913,261
Fee-For-Service	$530,074,554	$580,370,398	$401,184,851	$1,511,629,803
Total	$911,231,641	$937,814,279	$966,497,143	$2,815,543,063

RED FLAGS

- Member Complaints
- Certified Home Health Aide does not arrive at designated time frame or follow the plan of care
- Agencies are steering members
- Home Care Agencies that are billing more outliers than other agencies
- Certified Home Health Aides that are employed by more than one agency with high co-occurring claims volume

Home Care Fraud Schemes

- Home Care agency obtaining fraudulent certifications
- Using non-certified/unlicensed individuals to provide services
- Collaborating with physicians to approve home health care services when they aren't indicated
- When a home healthcare company with an ownership interest in an assisted living facility provides healthcare services at that facility

Home Care Fraud Schemes

- Billing for Services Not Rendered
  - Certified Home Health Aide does not show up
  - Home Care company bills for hours in excess of what was provided
  - Home Care company obtains member/recipient IDs and bills for services that were never provided or intended to be provided
  - Home Care company bills for services when recipient is the hospital or has been placed in a rehabilitation or nursing home

Home Health Care Requirements

Providing HHA Services

- Only HHAs can provide HHA services to Medicaid recipients
- HHAs must be supervised by a RN
- The RN must document assigned duties for the HHA

HHC approval documentation requirements

- Certification must be ordered and signed by the attending physician
- Prior authorization is required
- Plan of Care
  - Must be developed by the attending physician in conjunction with agency personnel
  - Reevaluated by nursing staff at least once every two months

Documentation

Records must accurately reflect all services that were rendered.

<u>If it is not documented …</u>
<u>it was not done.</u>

HHC DOCUMENTATION COMPLIANCE

Claims and timesheets must be completed accurately to include:

- Authorization
- Number of units
- Service date
- Licensing information

Documentation Standards

- All records must include:
  - Patient's name
  - Date of service
  - Signature of person making the entry

- Handwritten Records:
  - Must be legible
  - Must reflect all elements of what provider bills
  - Should be done when the services are rendered or as soon after that as possible

Medical Record Documentation

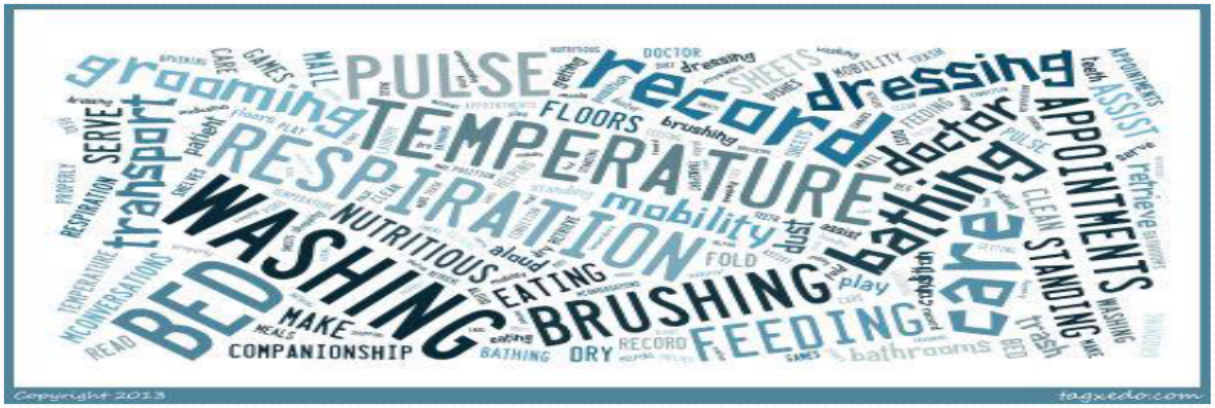
- Registered Nurse (RN)/Licensed Practical Nurse (LPN)
  - Nursing Plan of Care
  - Daily Clinical Notes and Progress Notes
  - Medication Administration Record
    - Documentation needed after the medication is given
    - Drug name and strength, date and time of administration, dosage, method deployed and signature of individual administering the medication
- Home Health Aide (HHA)
  - Written instructions from RN to HHA
  - Daily documentation of services provided
  - Supervisory visits

Medicaid Documentation Requirements-N.J.A.C. 10:49-9.8

- Providers shall agree to:
  - Keep records that are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for at least five years after the service was rendered;
  - To provide requested information about provided services;
  - Adjust payments when records do not document the extent of services billed

Plan of Care N.J.S.A. 10:60-2.3

- Beneficiary's major and minor diagnoses
- Case history including medical, nursing and social data
- Period covered by the plan
- Number and nature of service visits
- Copy of physician's orders
- Long- and short-term goals
- Discharge planning in all areas of care



Clinical Records N.J.S.A. 10:60-2.4

- Plan of care
- Appropriate identifying information
- Contact information for beneficiary's physician
- Clinical notes that are written, signed and dated on the day each service is provided by nurses, social workers and therapists
- Clinical progress notes
- Summary reports from nurses, social workers, and therapists which shall be submitted at least every two months the attending physician

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Good Example

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
123456789	01/01/2016	From: 01/01/2016 To: 02/29/2016	A002566	1234897

6. Patient's Name and Address
Home Health Patient
123 Service Road
Princeton, NJ

7. Provider's Name, Address and Telephone Number
Home Care R US
456 Landing Road
Trenton, NJ

8. Date of Birth | **9. Sex** ☑ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Tylenol w Codeine 60mg 2X daily

11. ICD-9-CM	Principal Diagnosis M54.5	Date 01/01/2016
12. ICD-9-CM	Surgical Procedure M25.512	Date 01/01/2016
13. ICD-9-CM	Other Pertinent Diagnoses R05	Date 01/01/2015

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations
1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted
1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☑ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☑ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☑ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
HHA 3X a week between 1-2 hours each session
PT 2X a week between 1-2 hours each session

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Jane Nurse, RN

25. Date HHA Received Signed POT
1-1-2016

24. Physician's Name and Address
Robert Doctor, MD
222 Green Road
Trenton, NJ.

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed
Robert Doctor, MD 12-28-15

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Bad Example

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
	01/01/2016	From: 1/1 To:		1234897

6. Patient's Name and Address
Home Health Patient

7. Provider's Name, Address and Telephone Number
Home Cares R Us

8. Date of Birth | **9. Sex** ☒ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Tylenol or Codeine

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations
1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
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18.B. Activities Permitted
1 ☐ Complete Bedrest
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B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
HHA, PT
Maybe OT

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
L.R.N. 1/1

25. Date HHA Received Signed POT
SAME

24. Physician's Name and Address
Robert Doctor, MD

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
ON FILE

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

Billing and Coding

It is the **provider's** responsibility to ensure that claims submitted for payment reflect the service provided. It is incumbent upon **providers** to be knowledgeable about the codes that are used to reflect the services rendered.

Claims Submission Requirements

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties

- **SIGNATURE OF PHYSICIAN (or SUPPLIER)**: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

- **NOTICE**: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material fact, may be prosecuted under applicable Federal or State laws.

“I didn’t mean to do it. It’s the computer’s fault, the billers fault, I didn’t know the codes to use….”

“Ignorance of the law excuses no one.”

John Seldon

Third Party Liability

Third Party Liability (TPL) exists when any party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid program.

It is the provider's responsibility to be aware of a patient's other insurance.

Third Party Liability

- Medicaid is the payer of **LAST** resort.
- A TPL's potential liability to pay for services ***cannot*** prevent a Medicaid beneficiary from receiving covered services.
- TPL Billing ***Dos & Don'ts***
  - Balance billing – **Don't**
  - TPL co-payment – **Don't**
  - TPL payment paid to the beneficiary - **Do**

Healthcare Fraud Cases

Maxim Healthcare Services, Inc.

- Initiated by a NJ patient – Qui Tam Lawsuit
- The patient alleged that Maxim
  - billed Medicaid for services not rendered
  - operated unlicensed offices
- Multi-jurisdiction investigation
- Results
  - $150 million global settlement
  - 8 Maxim employees pled guilty to Federal charges and were sentenced to imprisonment, home arrest and/or probation including
    - 2 high-level account managers and
    - 2 nurses

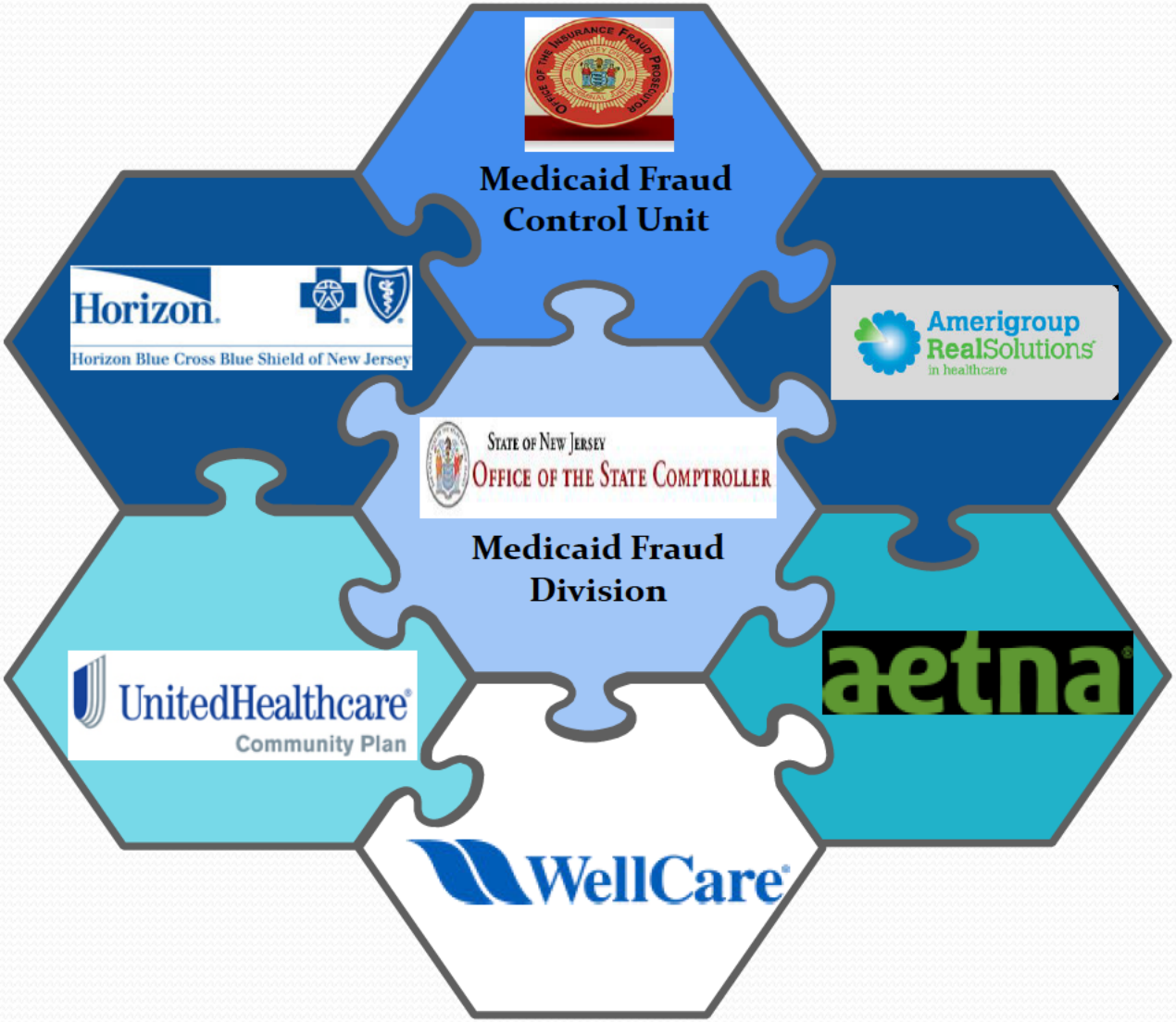
Touch of Life, LLC

- Fraudulently billed for services provided to Class C boarding home residents
- Because Medicare pays for personal care services for the residents, Medicaid regulations prohibit billing for home health aides in these facilities
- Results
  - Two owners and an office coordinator pled guilty to fraud
  - Sentences
    - Three years in state prison
    - Three years probation with 364 days house arrest
    - Three years probation with 50 hours of community service
  - $425,000 consent judgment against the owners

United States v. HHCH Health Care Inc. and People Choice Home Care Inc.

- Submitted claims for home health services that were not rendered
- Obtained state home health aide licenses fraudulently
- Submitted false claims for home health services provided by aides that were undocumented or individuals without state licenses
- Bribed state regulators investigating companies for not paying home health aides overtime
- Results
  - Approximate loss was $7 million
  - 11 initial arrest by the FBI and over two dozen follow-up arrests

MFD brings us together regularly to discuss FW&A issues



Compliance

- Compare claims and timesheets completed by CHHA to determine if the services were rendered
- Compare the health plan's authorized number of units/hours billed to the number of hours reimbursed to the agency for each date of service
- Compare the number of reimbursed units/hours to the timesheets
- Analyze claims to identify any overlaps in dates of services with inpatient hospital stays
- Generate CHHA license report to identify if aide is working for more than one agency
- Review any overlap in hours on a given date of service

Self-Disclosure

We support providers who find problems within their own organizations, reveal (self-disclose) those issues to the MFD and return inappropriate payments.

- ACA §6402 and NJAC §10:49-1.5 (b)(1), (7) require that providers return overpayment to Medicaid and/or Medicare within 60 days of identifying the overpayment.
- Failure to return an overpayment could result in penalties of between $5,500 and $11,000 per claim.

Self-Disclosure

- Advantages of Self-Disclosure
  - MFD'S self-disclosure policy is more liberal than the OIG's policy. If we agree with your analysis, we do not impose interest or penalties.
  - MFD'S Self-Disclosure policy can be found on our website at www.nj.gov/comptroller/divisions/medicaid/disclosure/

AFFORDABLE CARE ACT

- 42 CFR §455.450 contains the screening requirements for providers who wish to enroll in the Medicaid program.

Debarred Providers

- A debarred provider is a person or organization that has been excluded from participating in Federal- or State-funded health care programs.
- Any products or services that a debarred provider directly or indirectly furnishes, orders or prescribes are not eligible for payment under those programs.

MCO/MFD Recovery Actions

Once an overpayment has been identified, actions to initiate recoupment of the funds begin.

- MCO sends a letter to the provider with the overpayment amount
- MFD will either send a Notice of Estimated Overpayment or a Notice of Claim
- MFD may add false claim penalties between of between $5,500 and $11,000.

What you learned today

- All of the state agencies and MCOs that have oversight of your contracts and billing
- What the Medicaid Regulatory Framework looks like
- How the Medicaid requirements apply to you
- Your obligation to comply with rules and regulations for documentation and billing in order to avoid allegations of fraud, waste and abuse
- The penalties for noncompliance

Questions???

Thank you for attending.

How did we do?

Your opinion matters.

Please complete your evaluation form before you leave.