Developing Effective Processes to Improve HCBS Waiver and Habilitation Services Documentation

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Understanding the Big Picture

- Learning Objective: Develop a better understanding of how HCBS Services fits into the Medicaid System in Iowa.

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What is the Medicaid Program

- Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities.
- The Federal and State Governments jointly fund and administer the Medicaid program.
- Each State administers its Medicaid program in accordance with a CMS-approved State plan.
- Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

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What is the Medicaid Program

- The Social Security Act authorizes all Medicaid services including home and community-based services (HCBS) programs.
- Iowa's HCBS waiver and HCBS Habilitation State plan must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid.
- The state Medicaid agency must administer the program, yet can contract with other appropriate entities to perform some functions such as monitoring, certifications, licensing, and technical assistance.

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Iowa Medicaid Benefits Overview

Mandatory Medicaid Benefits	Some Optional Medicaid Benefits
• Physician services • Laboratory and x-ray services • Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 • Family planning • Rural and federally-qualified health center (FQHC) services • Nurse midwife services • Nursing facility (NF) services for individuals 21 or over • Home health care for persons eligible for nursing facility care • Pediatric and family nurse practitioner services • Non-emergency transportation to medical care • Smoking cessation for pregnant women	• Prescription drugs • Clinic services • Dental services, dentures • Physical therapy and rehab services • Prosthetic devices, eyeglasses • HCBS waiver • HCBS habilitation • Outpatient mental health services • Intermediate care facilities for the mentally retarded (ICF/ID) services • Personal care services • Hospice services • Case Management • Chiropractic services • Durable medical equipment • Other services approved by the Secretary

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Purpose of the HCBS waiver program

- The Iowa Department of Human Services Medicaid Home- and Community-Based Services provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution, an ICF/ID, Nursing Facility, or Skilled Nursing Facility.

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Purpose of the HCBS Habilitation Program

- The Medicaid Home- and Community-Based Services Habilitation program provides service funding and individualized supports to maintain eligible members in their own homes or communities who require assistance due to the functional limitations typically associated with chronic mental illness.
- The HCBS Habilitation Program replaced the Adult Rehabilitation Option (ARO).

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Understanding the Big Picture

- Learning Objective: Develop a better understanding of the importance that service documentation complies with IAC Chapter 79.3 rules.

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HHS Office of Inspector General Audits and Evaluations of Medicaid Services

- Generally the objective is to determine whether the State agency or individual provider claimed Federal Medicaid reimbursement in accordance with Federal and State requirements.
- At times the objective is to determine whether Medicaid waste, abuse, or fraud has or is occurring.

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HHS Office of Inspector General Audits and Evaluations of Medicaid Services

- Reasons for recoupment on OIG audits include billing for services with no documentation, billing for services that were not adequately documented (errors in meeting State rules), billing for services when the member was not present for services, and billing without an approved service (care) plan.
- Recoupment for these errors can result in millions of dollars refunded by the State or individual provider.

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Iowa's Adult Rehabilitation Option OIG Audit

- For Federal Fiscal Year 2002, $6,244,154 of the $10,563,635 in Federal funds that the State claimed for FFY 2002 was unallowable.
- Iowa refunded $6,244,154 to the Federal government.
- Reasons for recoupment included: Documentation was missing or inadequate for 65 out of 100 claims, and no services were provided or the beneficiaries were not present for 11 out of 100 claims.
- Documentation errors: 56 claims had missing required elements of documentation, 17 claims had no narrative, and 12 claims had no documentation.

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Iowa's Adult Rehabilitation Option OIG Audit

- As a result of the ARO audit, Iowa DHS revised service documentation rules in Chapter 79.3 a number of times to better comply with Federal requirements.
- Iowa DHS started to conduct more provider specific desk and on-site audits of service documentation.
- Iowa DHS did start to recoup payment for services as a result of findings on service documentation audits.

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Iowa's Health Home OIG Audit

- Iowa improperly claimed Federal Medicaid reimbursement for payments made to health home providers that did not comply with Federal and State requirements. Specifically, Iowa's health home providers did not document core services, integrated health home outreach services, diagnoses, and enrollment with providers.
- OIG recommends that Iowa refund $37.1 million to the Federal government. Iowa should also improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for documenting the services for which the providers billed and received payments. We also recommend that Iowa revise its State Medicaid plan to define documentation requirements and that Iowa educate providers on these requirements.

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DHS Audits or Reviews of Provider Clinical and Fiscal Records

- Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.
- Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether: (1) the department has correctly paid claims for goods or services; (2) the provider has furnished the services to Medicaid members; (3) the provider has retained clinical and fiscal records that substantiate claims submitted for payment; (4) the goods or services provided were in accordance with Iowa Medicaid policy.

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DHS Audits or Reviews of Provider Clinical and Fiscal Records

- If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.
- If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

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DHS Audits or Reviews of Provider Clinical and Fiscal Records

- Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.
- A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441- Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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Understanding the Big Picture

- Learning Objective: Learn how to develop organizational processes and habits that can help improve service documentation at the DSP level.

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2019 IACP Analysis of Corrective Action Plans for 74 Agencies

- Specific interventions/supports, including name, dosage and route of medications administered (41%)
- Member's response to staff interventions/supports (35%)
- Process to ensure units of service billed for payment are based on services provided with substantiating documentation (35%)
- At a minimum, service documentation shall include specific location, date, and times of service provision (34%)

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CMS Rules on Billing FMAP

- Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Supporting documentation includes, at a minimum the following: date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service. Do not report estimated amounts. Claims developed through the use of sampling, projections, or other estimating techniques are estimates and are not allowable.

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DHS Rules for Billing for HCBS Services

- IAC 79.3 Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format.
- All Medicaid providers must document in a narrative format and follow Chapter 79.(3) 1 through 9 rules.

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We are what we repeatedly do… therefore excellence is not an act, but a habit.

- Will Durant

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IAC Chapter 79.3 rules: Service Documentation Treatment and Procedures

- The specific procedures or treatments performed. Documentation must be a narrative, including interventions and responses. Checklists may be utilized.
- The treatment and procedures agencies provide are grounded in the community-based case manager service plan and provider plan. The provider plan provides the specifics on how best to support the client, based on the case manager's plan.

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IAC Chapter 79.3 rules: Service Documentation Treatment and Procedures

- IAC Chapter 78 lists the service components that can be provided for specific HCBS service(s) the provider is approved to provide in the case manager plan. As an example, Chapter 78.41(1) a. (1) through (7) lists the available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.
- Providers need to familiarize themselves with the available components of the services rules they are approved to provide.

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IAC Chapter 79.3 rules: Service Documentation Treatment and Procedures

- Interventions or staff actions include, but are not limited to, prompted, modeled, verbally reminded, physically assisted, assisted, supported, and explained.
- Responses include how the client responded to the staff interventions/actions. What did the client say or do? How did they respond to the staff interventions? Did they actively partake in the learning and supports? Did they participate in and/or accomplish their goals/objectives? Did they actively participate in the supports? Did they accomplish what was prompted or requested?

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IAC Chapter 79.3 rules: Service Documentation Treatment and Procedures

- Please do not over prompt or intervene. This creates dependency and negatively affects the client's ability to learn. Allow them a short time to process after a prompt. Ask questions, gesture, or use some physical assistance over too much verbal prompting.
- The written narrative needs to be specific and to the point, including staff interventions and client responses. You do not need to write a book, the narrative needs to get to the point regarding the outcome of working on goals/objectives and/or providing of approved supports in the case manager's service plan.
- For daily SCL or HBH, there needs to be narrative documentation of supports provided or implementation of assigned goals/objectives for each shift.

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IAC Chapter 79.3 rules: Service Documentation Dates and Time of Services.

- The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
- The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. All HCBS services are a time-related service, even daily SCL and HBH.
- Since all HCBS services are time-related, the service documentation needs to include time in and out from each approved service (ex: SCL, HBH, Day Habilitation, Community Employment).
- Be aware if an agency provides both SCL/HBH and day services. Be sure the clock in and out times do not conflict within each service's service documentation. The same holds true if the agency provides SCL/HBH and the client receives day or employment services from another agency.

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Remember Rounding Rules

- IL 1226 – Review for a refresher on how to round.
- https://dhs.iowa.gov/sites/default/files/1226DetailsofAtypicalConversionDocumentationandBilling.pdf?091620192026

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IAC Chapter 79.3 rules: Location of services

- The location where the service was provided if otherwise required on the billing form.
- The specific location is generally included in the narrative, ex: Susan's home, Joe's job at Walmart in specific city, grocery shopping at Target in City (if more than one Target in city, best to provide the address), Dr. Kildare's medical office in city.

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IAC Chapter 79.3 rules: administration of medication and supplies

- The name, dosage, and route of administration of any medication dispensed or administered as part of the service. This is the medication administration record (MAR). The agency needs to follow policies and procedures on the administration, storage, and disposal of medications. A best practice would be after documenting the administration of medications in the MAR, to make a note in the narrative that the medications were administrated, as simple as: "Staff provided prompting and assistance to Joe to take his medications, and Joe responded by taking all his medications. See MAR."
- Any supplies dispensed as part of the service. This is the medication administration record.

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IAC Chapter 79.3 rules: Service Documentation name and signature

- The first and last name and professional credentials, if any, of the person providing the service.
- The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
- If an agency uses acronyms in their narrative documentation, create a legend that corresponds to each acronym.

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Corrections Before submitting a claim for reimbursement

- Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
- A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
- Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.
- If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

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It's not enough that we do our best. Sometimes we have to do what is required.

- Winston Churchill

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DSP training on Service Documentation, Thinking Differently

- Adult learning principles note that only about 20% of what is presented in an auditory training such as today is retained by the learner. If the learner does not keep notes, they will only retain about 10% to 15% of what they learned within a week after the training. If the learner does not apply what they learned, retention of learning drops to under 10% retained.
- Adult learning principles note that if the learner keeps notes and applies the new learning, over 85% of the new learning will be retained. If the learner continues to apply the new learning and conducts quality assurance or reviews on the application of the new learning, retention is over 95% of what was learned.
- Adult learning principles note that if the learner also uses visual reminders after applying the new learning, retention is close to 99%.

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DSP training on Service Documentation, Thinking Differently

- Adult learning principles: There are generally four types of learning style: auditory, visual, reading/writing, and kinesthetic. Every learner has a different style of learning or combination of learning style. Today's presenter's style of learning is visual along with reading and writing.
- **Visual** learners are the most common type of learner, making up 65% of our population. **Visual** learners relate best to written information, **notes**, diagrams, and pictures. They do not work well with someone just telling them information. They work better when you can write the information down!

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DSP training on Service Documentation, Thinking Differently

- How do adult learners learn best? While seeing information and then writing it down is important, actually putting new knowledge and skills into practice can be one of the **best** ways to improve **learning**.
- Teaching the DSP to evaluate their own work product for accuracy and completeness is critical to learning the new skill or practice.
- Having period reviews by the supervisor/leadership/quality assurance on the work product of the DSP with feedback is critical to the learning of the new skill or practice.
- All this results in a more errorless teaching approach and learning style for DSP's.

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DSP training on Service Documentation, Thinking Differently

- Service documentation shall include narrative documentation and may also include documentation in checkbox format.
- Checklists could be developed for orientation of new DSP's on completion of services documentation. Simple videos of experienced DSP's implementing goals and supports could be developed, and newly hired DSP's answer questions on what they observed. DSP's could observe the videos and document the location of services and staff interventions and responses they observed, then write up a narrative from the notes. The trainer could then give them feedback.

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DSP training on Service Documentation, Thinking Differently

- Self-assessment of service documentation checklists could be developed and have newly hired and existing DSP's utilize the checklist to self evaluate their narratives. Based on their own assessment, they could correct their documentation. DSP's would turn in the self-assessment to the supervisor/leadership.
- Supervisors/leadership could periodically complete a self-assessment checklist of DSP's service documentation then review the findings with the respective DSP.

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DSP training on Service Documentation, Thinking Differently

- A daily checklist could be developed that includes a list of goals/objectives and key supports to document on specific to the client. DSP's could circle the type of interventions and responses on each goal/objective and support, along with specific location, and make some quick notes. DSP's could then later complete their narrative service documentation.
- Peer Review - DSPs giving each other feedback and checking for common errors
- Each agency needs to have a quality assurance program to meet the self-assessment requirements.

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The measure of intelligence is the ability to change.

- Albert Einstein

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Resources

- IACP has already provided excellent training on service documentation. The following links can be accessed to review past PowerPoint presentations on service documentation:
- https://www.iowaproviders.org/assets/docs/TA%20Documentation%206.2019.pptx
- https://theiacp.memberclicks.net/assets/docs/TechnicalAssistance/TASpring2019Regional/Documentation%20April%2020219%202.pptx

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Questions??

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