inarf SINCE 1974

Financial Management Professional Interest Section Meeting

August 11, 2022

Today's Agenda

- Welcome
- Upcoming Events
- Group Home Compliance Review and Cost Reports
- Electronic Visit Verification

Upcoming Events

Professional Interest Section Meetings / Professional Development:

- August 11 - Human Resources (12:30-2:30 PM)
- August 18 - Child & Family Services (10 AM-Noon)
- October 20 - Community Supports (10 AM-Noon) / Employment Supports (12:30-2:30 PM)

Upcoming Member Forum and Board of Directors Meetings:

- August 26, 2022 - PAC Legislative Reception / Member Forum / Board of Directors Meeting
- September 23, 2022 - Board of Directors Meeting / No Member Forum
- October 28, 2022 - Member Forum / Board of Directors Meeting

Registration opens 3 weeks in advance. To register for open events, scan the QR code or go to https://web.inarf.org/events

2022 Pre & Annual Conference

Register today by scanning the QR code or visit
www.inarf.org/2022_annual_conference.html

Sponsorship Recognition

Group Home Compliance Review and Cost Reports

Adam Langford, Senior Manager, Myers & Stauffer

Melissa Baumgart, CPA, CGMA, Senior Manager, Myers & Stauffer

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

GROUP HOME COST REPORTS AND COMPLIANCE REVIEWS

AUGUST 11, 2022

PRESENTED BY: MISSY BAUMGART AND ADAM LANGFORD

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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OVERVIEW OF COST REPORTS

- Myers and Stauffer LC website contains a lot of resources including announcements, forms / instructions, and reporting
  https://www.mslc.com/Indiana/

- Facilities are reimbursed under 405 IAC 1-12

- Cost Report Due Dates:
  - Annual Cost Reports are due 90 days following fiscal year end
  - Historical Cost reports are due 60 days following report year end

- Almost all, if not all, organizations request a 90-day extension

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OVERVIEW OF COST REPORTS

- Most submissions are during the last week of the extended due date and the subsequent 30-day delinquent period [“grace period”].
  - Submission on the last day does not allow for Myers and Stauffer LC review to determine if all required items are submitted.
    - May result in penalty if items are missing or cost report is unsigned.

- 100% of organizations are signed up for the LTC Web Portal
  - Communication from our office is only sent via LTC Web Portal
  - Providers typically submit all information via the LTC Web Portal. Although the LTC Web Portal is the preferred submission method, paper may still be submitted via standard mail (USPS, UPS, FedEx) or hand delivered.

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RATE SETTING PROCESS

- Myers and Stauffer LC reviews cost report submission

- Sometimes a request for additional information [RAI or writeback] is needed
  - Response is requested within 30 days. If a response is not received within 30 days, a second request is sent after 30 days, then a third and final request is sent after an additional 30 days.

- Common rate setting adjustments include:
  - Adjustment to overall revenue
  - Incorporation of compliance review findings
  - Capitalization of operating leases

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RECONSIDERATION AND APPEAL PROCESS

- Release of Medicaid rate starts the reconsideration process
  - Request for reconsideration must be received within 45 days of release of rate
  - Response to reconsideration sent within 45 days of request

- After the reconsideration process is complete, if the provider is in disagreement, an appeal may be filed
  - Should be filed with Office of the Secretary of the Indiana Family and Social Services Administration c/o Derris Harrison.
  - Appeal must be filed within 15 days of reconsideration response
  - Statement of Issues must be filed within 45 days of reconsideration response

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RECENT CHANGES DUE TO COVID

- Typical 2-year cycle of Rebase then Non-Rebase
  - 10/1/18 – 9/30/19 ~ Rebase Year
  - 10/1/19 – 9/30/20 ~ Non Rebase Year
  - 10/1/20 – 9/30/21 ~ Rebase Year
  - 10/1/21 – 9/30/22 ~ Non Rebase Year
  - 10/1/22 – 9/30/23 ~ Rebase Year
  - 10/1/23 – 9/30/24 ~ Non Rebase Year
- COVID impacted this cycle
  - Changed 10/1/20 – 9/30/21 & 10/1/21 – 9/30/22 to COVID Non Rebase Years based on 10/1/18 – 9/30/19 Rebase Year
  - 10% Direct Care Workforce Add-On effective July 1, 2021

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RECENT CHANGES DUE TO COVID

Year End	RED	Type	What's Released?	CR Data in Median?
6/30/2018; 8/31/2018; 9/30/2018; 12/31/2018	10/1/2018; 12/1/2018; 1/1/2019; 4/1/2019	Rebase Year	Medicaid Rebase Rate & Associated Rebase Profile	Yes
6/30/2019; 8/31/2019; 9/30/2019; 12/31/2019	10/1/2019; 12/1/2019; 1/1/2020; 4/1/2020	Non Rebase Year	Medicaid Non Reabase Rate & Associated Allowable Cost Determination Profile	Yes
6/30/2020; 8/31/2020; 9/30/2020; 12/31/2020	10/1/2020; 12/1/2020; 1/1/2021; 4/1/2021	Rebase Year	Medicaid Rebase Rate & Associated Rebase Profile	Yes
6/30/2021; 8/31/2021; 9/30/2021; 12/31/2021	10/1/2021; 12/1/2021; 1/1/2022; 4/1/2022	Non Rebase Year	Medicaid Non Reabase Rate & Associated Allowable Cost Determination Profile	Yes
6/30/2022; 8/31/2022; 9/30/2022; 12/31/2022	10/1/2022; 12/1/2022; 1/1/2023; 4/1/2023	Rebase Year	Medicaid Rebase Rate & Associated Rebase Profile	Yes
6/30/2023; 8/31/2023 9/30/2023; 12/31/2023	10/1/2023; 12/1/2023; 1/1/2024; 4/1/2024	Non Rebase Year	Medicaid Non Reabase Rate & Associated Allowable Cost Determination Profile	Yes

Year End	RED	Type	What's Released?	CR Data in Median?	10% Add-on?
6/30/2018; 8/31/2018; 9/30/2018; 12/31/2018	10/1/2018; 12/1/2018; 1/1/2019; 4/1/2019	Rebase Year	Medicaid Rebase Rate & Associated Rebase Profile	Yes	No
6/30/2019; 8/31/2019; 9/30/2019; 12/31/2019	10/1/2019; 12/1/2019; 1/1/2020; 4/1/2020	Non Rebase Year	Medicaid Non Reabase Rate & Associated Allowable Cost Determination Profile	Yes	No
6/30/2020; 8/31/2020; 9/30/2020; 12/31/2020	10/1/2020; 12/1/2020; 1/1/2021; 4/1/2021	COVID Non Rebase	Medicaid Non Rebase COVID Rate	No	No
6/30/2021; 8/31/2021; 9/30/2021	10/1/2021; 12/1/2021; 1/1/2022	COVID Non Rebase	Medicaid Non Rebase COVID Rate	No	Yes
12/31/2021	4/1/2022	COVID Non Rebase	Medicaid Non Rebase COVID Rate & Associated Allowable Cost Determination Profile	Yes	Yes
6/30/2022; 8/31/2022; 9/30/2022; 12/31/2022	10/1/2022; 12/1/2022; 1/1/2023; 4/1/2023	Rebase Year	Medicaid Rebase Rate & Associated Rebase Profile	Yes	No
6/30/2023; 8/31/2023 9/30/2023; 12/31/2023	10/1/2023; 12/1/2023; 1/1/2024; 4/1/2024	Non Rebase Year	Medicaid Non Reabase Rate & Associated Allowable Cost Determination Profile	Yes	No

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COMPLIANCE REVIEW PROCESS

- OMPP authorizes costs reports to be reviewed
- Two levels of review
  - Compliance Review – Detailed review
  - Enhanced Review – Procedures are more limited than a Compliance Review
- Reviews are scheduled throughout the State Fiscal Year (7/1-6/30)
- Our office contacts selected providers to schedule their review
- Scheduling letters are sent to confirm the agreed upon dates
  - Compliance Review Scheduling Letter
  - Enhanced Review Scheduling Letter

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REVIEW WORK

- Pre-Review period work
  - Scheduling information is reviewed and sample selections (Invoices, Patient Personal Fund Accounts, Inquiries) are made and sent prior to review
- Review Work
  - Entrance Conference – discussion of outstanding info, process, questions
  - Additional requests, samples, questions are sent to provider and calls or meetings are set up as necessary to resolve
  - Exit Conference – Discussion of known adjustments, issues, outstanding information. Occurs at conclusion of field work.

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REVIEW WORK – CONT.

- Post-field Work
  - Exit conference letter (30 days to respond to request)
  - Additional Letters may be sent
  - Potential for a 10% rate reduction if responses are not provided to information requests (have not had to apply rate reduction to any GH provider due to non-responsiveness)
- Compliance review wrap up
  - Accountant completes review work
  - Review is subjected to internal review (could potentially lead to a new information request)
  - Upon completion of internal review, Draft Reports are issued

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DRAFT AND FINAL REPORTS

- Draft Report(s)
  - 30 days to respond to draft report (an extension of an additional 30 days is available – e-mail alangford@mslc.com to request)
  - Upon receipt of provider agreement, draft response, or at end of draft response due date, we begin finalization of review
- Final Report(s)
  - If a draft response was received, included with final report(s) is our response to the draft response
  - Include Final Compliance Review Report(s) as well as Preliminary rates
  - Typically issued within 45 days of receipt of draft response

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RECONSIDERATION

- Provider has 45 days after issuance of Final Report(s) to send in a reconsideration (a disagreement of preliminary compliance rates)
- If a reconsideration is received, our response and the finalized compliance review rates will be released within 45 days after receipt of the reconsideration.
- If a reconsideration is not received, the finalized compliance review rates will be released in a similar time frame after the Provider's 45 days have lapsed
- When the preliminary compliance review rates are finalized, they will be sent to the claims processor. **This is when any recoupments will begin to be processed**

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APPEAL

- If disagreement still exists, an appeal may be filed with the Office of the Secretary no later than sixty (60) days after issuance of the reconsideration response.
- Only issues that are raised in the reconsideration may be raised in an appeal.
- Legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees incurred as the result of an appeal are not allowable costs

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COMMON COMPLIANCE REVIEW ADJUSTMENTS

- Disallowance of RX and OTC Drugs
- Capitalizations
- Expense removals due to lack of adequate supporting documentation
- Reclassification of Owner/Related Party/Management Personnel wages to Owner/Related Party/Management Personnel line of cost report (Line 383)

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QUESTIONS

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CONTACT INFORMATION

Name	Position	Function	Email
Dan Brendel	Principal	Overall	dbrendel@mslc.com
Greg Cecil	Sr. Manager	Rate Setting/MDS	gcecil@mslc.com
Missy Baumgart	Sr. Manager	Rate Setting	mbaumgart@mslc.com
Adam Langford	Sr. Manager	Audit	alangford@mslc.com

Office Phone	317.846.9521
Toll-Free	800.877.6927

Electronic Visit Verification

Michael Cook, Director of Provider Services, OMPP

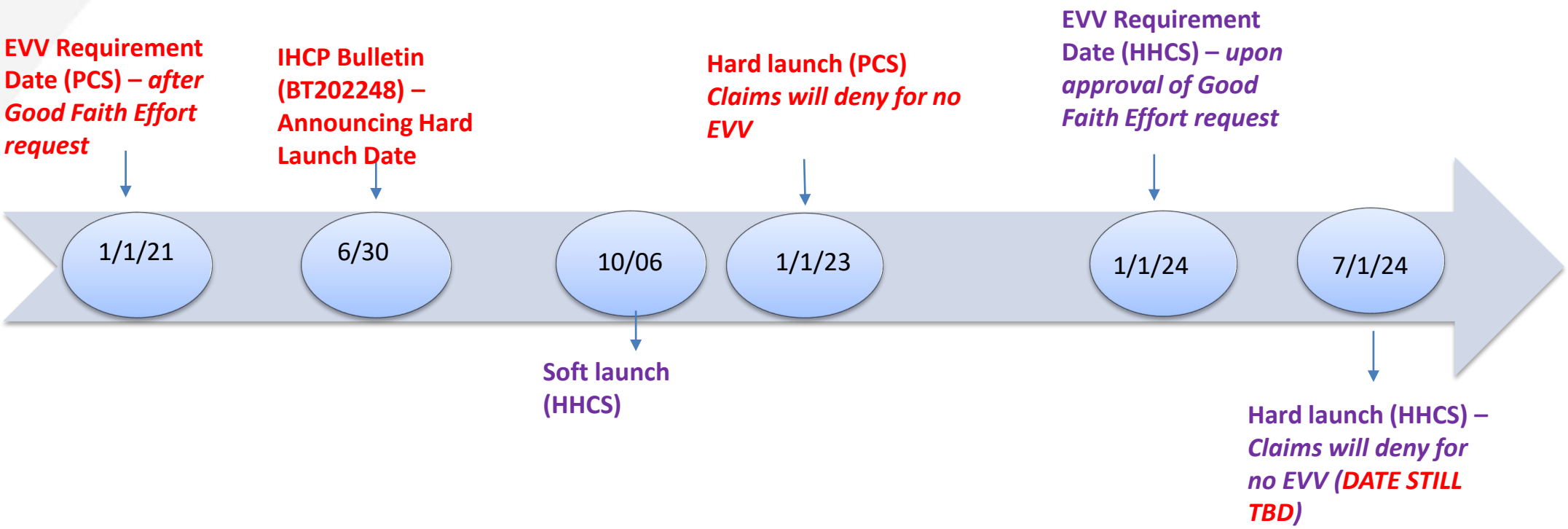
Darcy Tower, Director of Provider Experience, OMPP

Electronic Visit Verification (EVV)

INARF Presentation

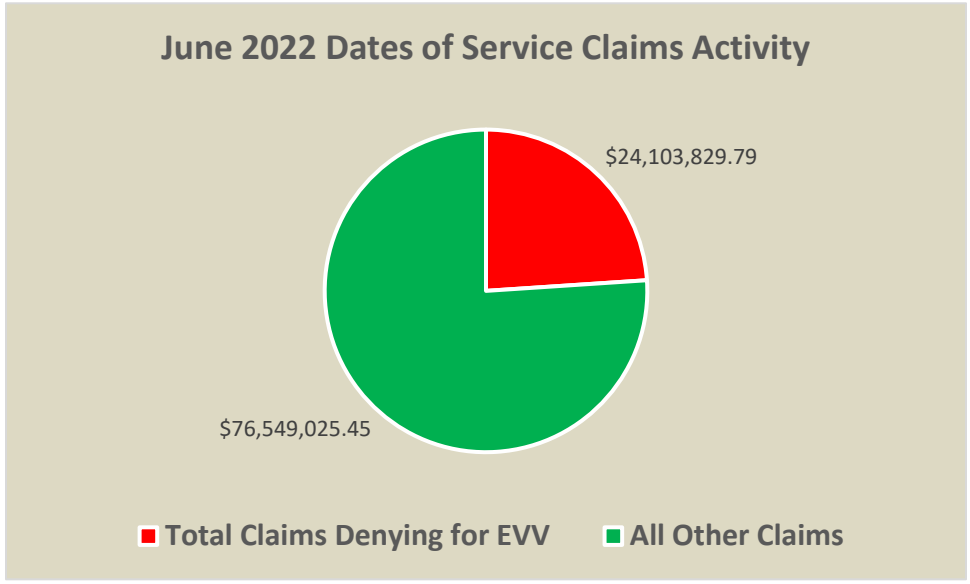
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
2022

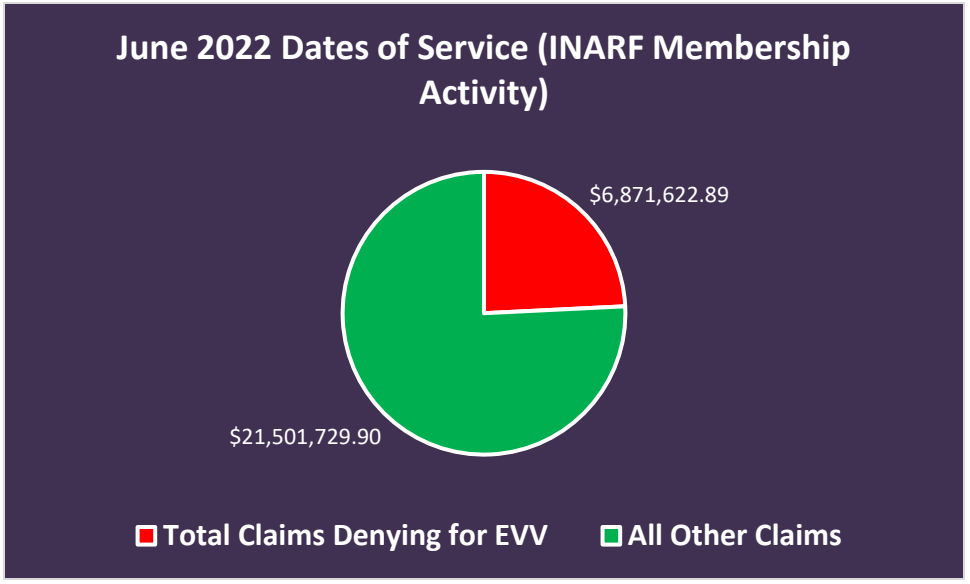
High-Level EVV Implementation Timeline



OMPP will request Good Faith Effort exemption for home health services

June 2022 Claims Activity





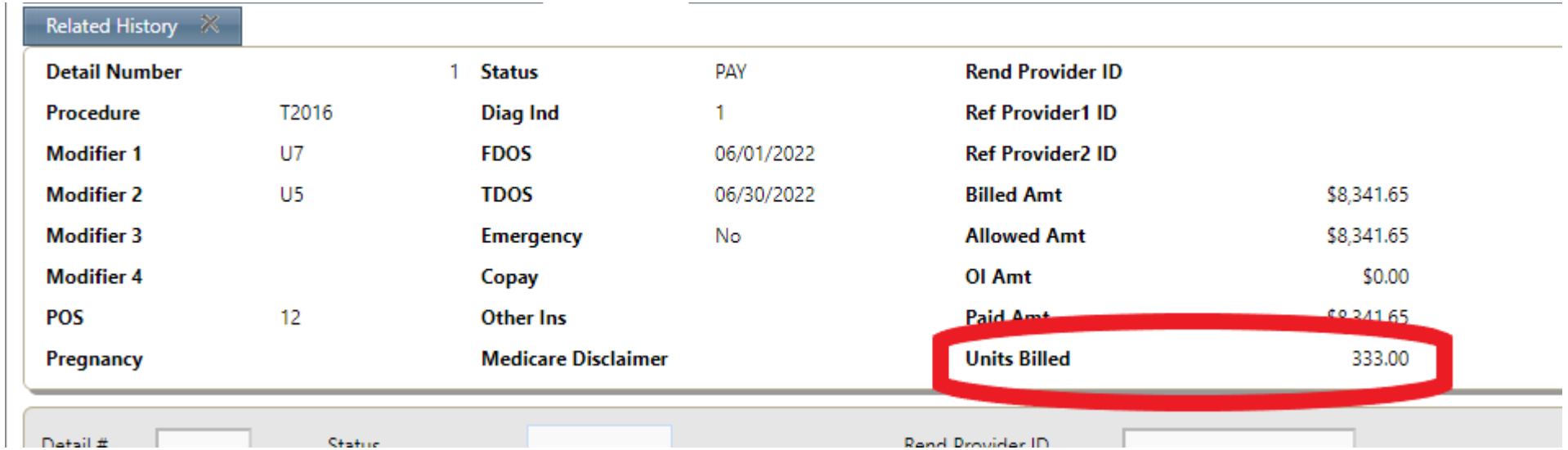
Customer Support Metrics

Problem Solving Claim Denials

Explanation of Benefit (EOB)	Questions to ask:
0950 / 0951	• Are you reviewing the Sandata Aggregator to ensure there are **verified records** for the date(s) of service on the claim? • If using an alternative vendor, did you bill **after** your vendor submitted records to the Aggregator? • Is your vendor up-to-date on technical specifications identifying specific services? • Did you select the correct service to be billed against the EVV record?
0952	• Did you bill at or below the number of units reflected on the EVV record(s), especially if the billing was over a period of time?

Claim Tips

- **Mismatch between the EVV record amount and the units billed on the claim (due to incomplete records):**



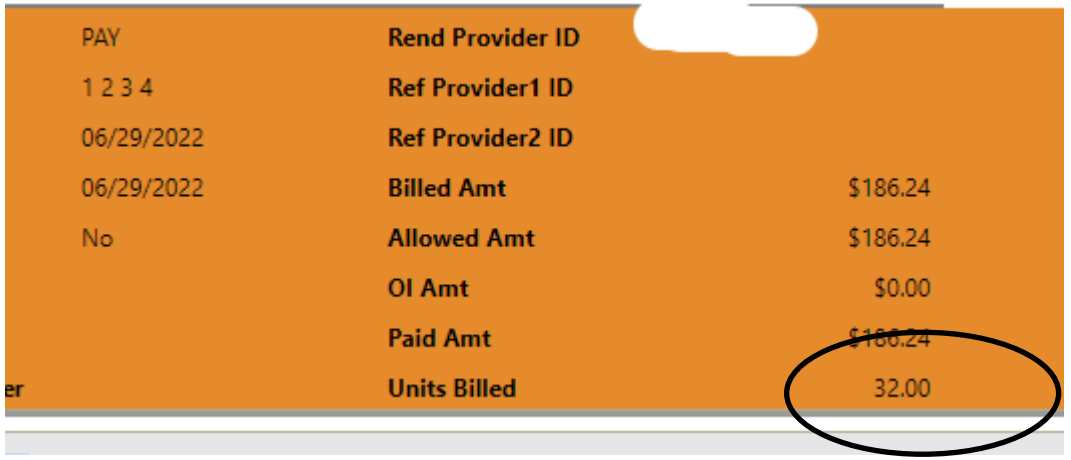
In the Sandata Aggregator, this member only had 130.75 verified units

SOLUTION – Make sure to clear any exceptions and verify records/unit amounts

Claim Tips

- **Mismatch between the EVV record amount and the units billed on the claim (just not enough units):**

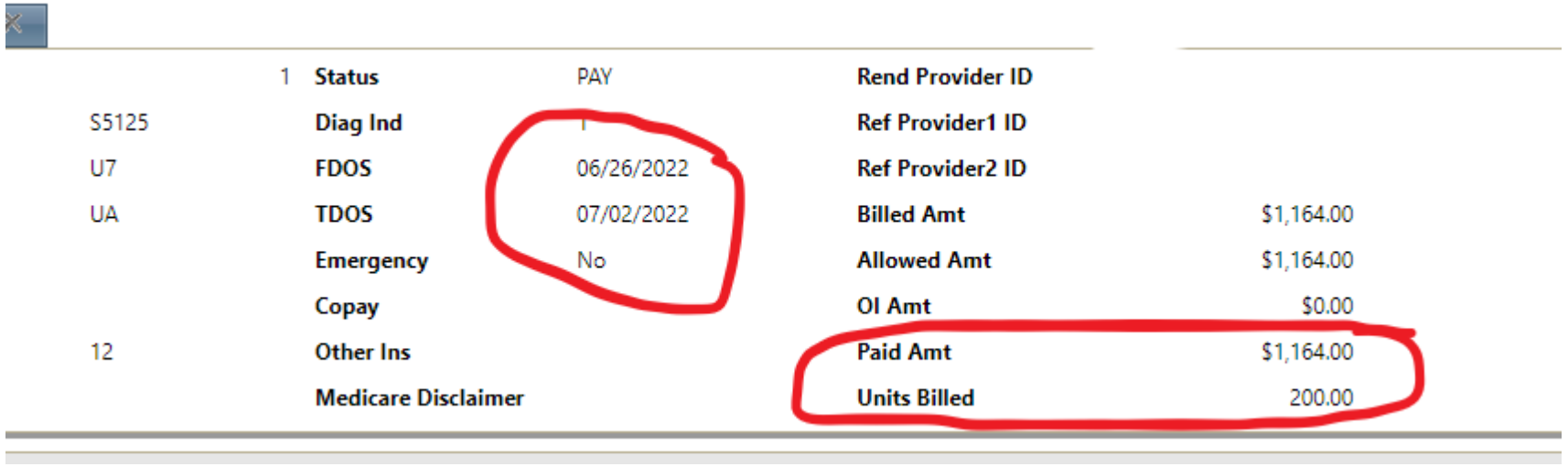
TO DATE	VISIT TIME ZONE	VISIT STATUS
06/29/2022	US/Eastern	Verified
CALL OUT	**CALL HOURS**	**UNITS**
01:58 PM	04:53	20
ADJUSTED OUT	**BILL HOURS**	
01:58 PM	04:53	



SOLUTION – Make sure to clear any exceptions and verify records/unit amounts

Claim Tips

- **Mismatch between the EVV record amount and the units billed on the claim (extending beyond the calendar month):**



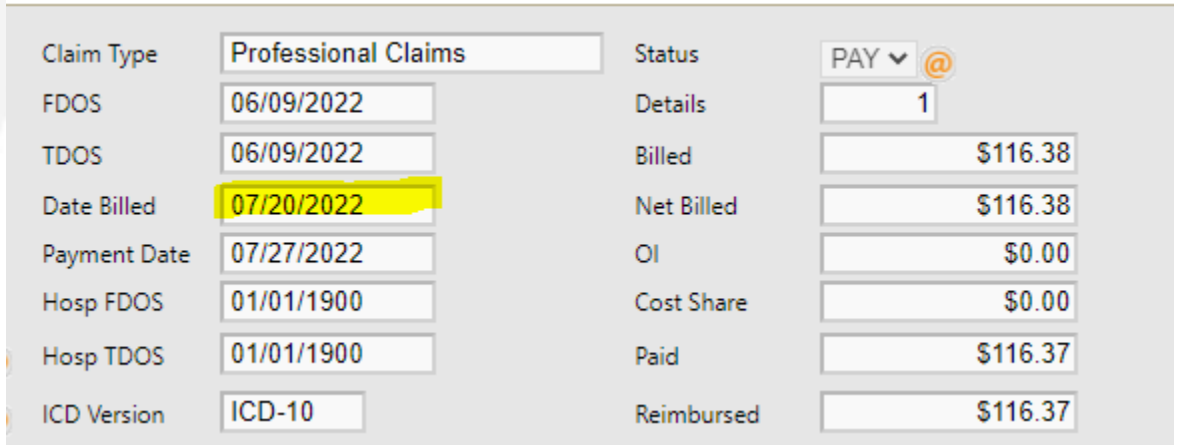
	1	Status	PAY	Rend Provider ID	
S5125		Diag Ind	1	Ref Provider1 ID	
U7		FDOS	06/26/2022	Ref Provider2 ID	
UA		TDOS	07/02/2022	Billed Amt	$1,164.00
		Emergency	No	Allowed Amt	$1,164.00
		Copay		OI Amt	$0.00
12		Other Ins		Paid Amt	$1,164.00
		Medicare Disclaimer		Units Billed	200.00

EVV activity will only match during the same calendar month being billed.

SOLUTION – Stay within the calendar month for billing

Claim Tips

- EVV Record Updates Performed After Claim Billing (**major concern for alternative vendor users**):



Claim Type	Professional Claims	Status	PAY @
FDOS	06/09/2022	Details	1
TDOS	06/09/2022	Billed	$116.38
Date Billed	07/20/2022	Net Billed	$116.38
Payment Date	07/27/2022	OI	$0.00
Hosp FDOS	01/01/1900	Cost Share	$0.00
Hosp TDOS	01/01/1900	Paid	$116.37
ICD Version	ICD-10	Reimbursed	$116.37

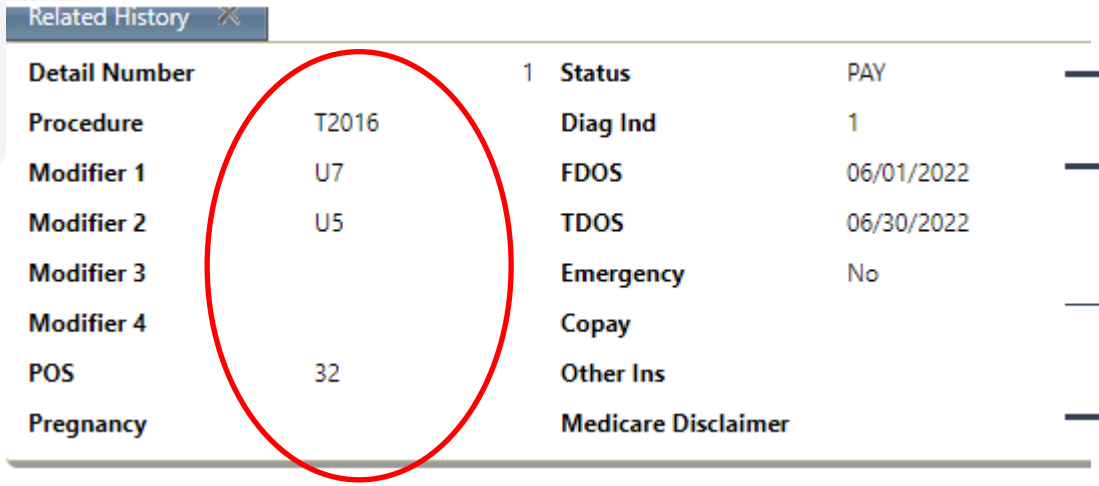
ITEM	DATE
Visit Received	7/25/2022 3:51:10 PM

EVV activity needs to be posted into the Aggregator prior to billing.

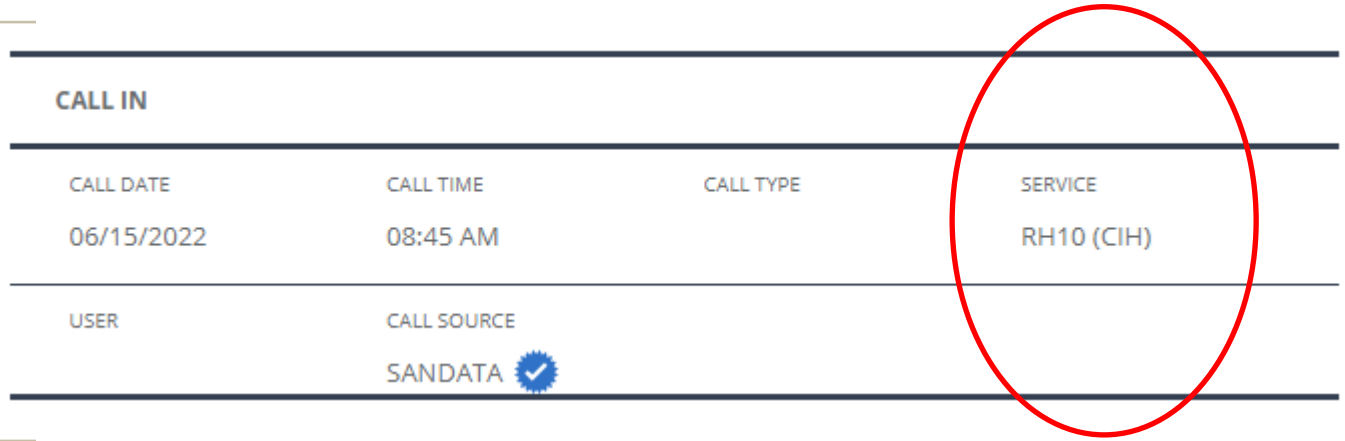
SOLUTION – Ensure your alternative vendor uploads data on a regular basis.

Claim Tips

- **Incorrect Service Selected on EVV Record:**



Claim Billed as RH10 (Residential Habilitation, 35 or Less Hours)



EVV record chosen as RH20 (Residential Habilitation, Over 35 Hours)

SOLUTION – Verify that your caregivers are selecting the right service; verify that your alternative vendor is following the technical specifications for service identifications.

Claim Tips

- **High Number of Manual Records:**

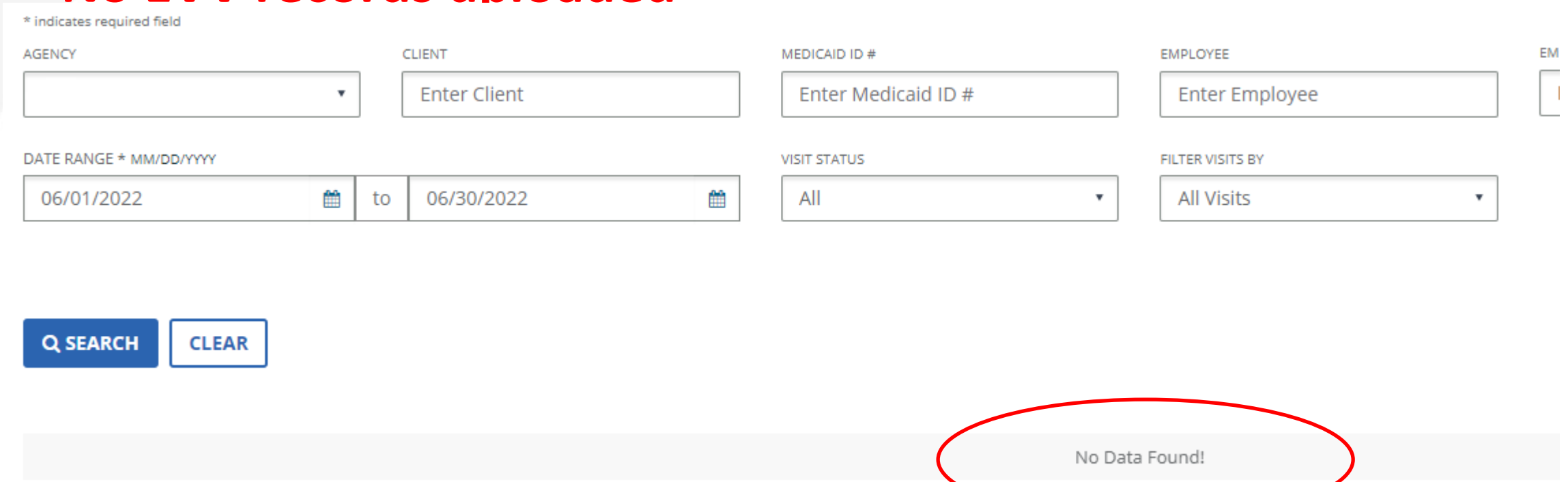
Example of a provider reviewed

Start Call Type	Total
MANUAL	814
MVV	65
(blank)	4
Grand Total	883

SOLUTION – Only use manual records on an emergency basis.

Claim Tips

- **No EVV records uploaded**



SOLUTION – Verify your alternative vendor is submitting records; verify your direct care workers are capturing visits.

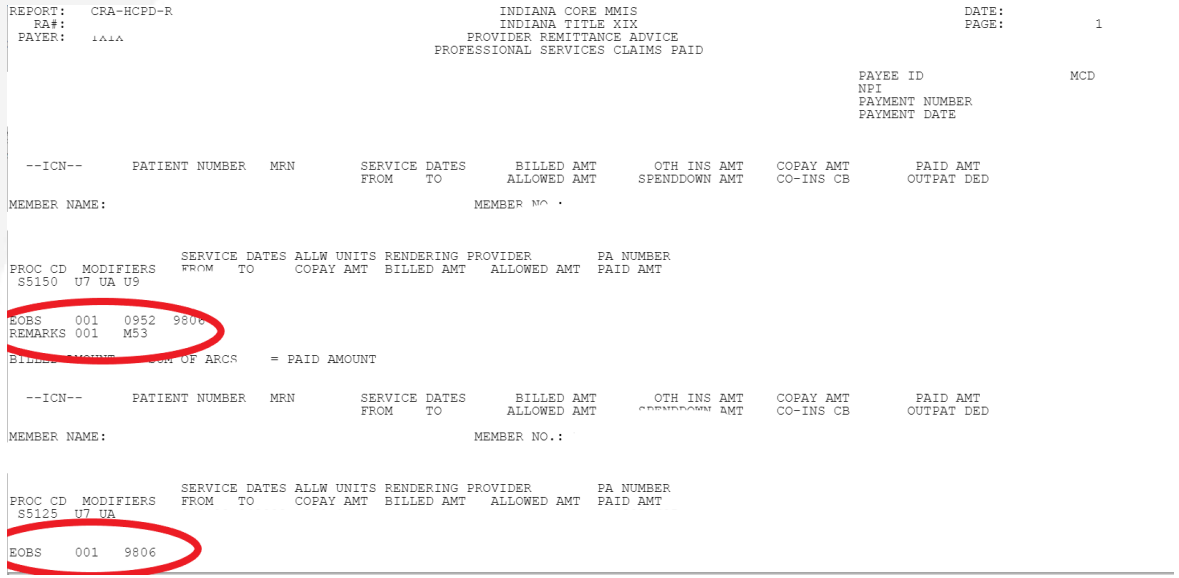
Key Suggestions to Ensure Compliance

1. Ensure alternative EVV records are submitted **prior to billing** and are seen **in the Aggregator**

2. Ensure that your alternative EVV vendor is **following the specifications around procedure code/modifier combinations**

3. Use the **Aggregator reporting tools** to make sure your visits are correctly submitted

Checking Claims on RA



```
REPORT:   CRA-HCPD-R                          INDIANA CORE MMIS                              DATE:
   RA#:                                       INDIANA TITLE XIX                              PAGE:          1
 PAYER:   IXIX                             PROVIDER REMITTANCE ADVICE
                                        PROFESSIONAL SERVICES CLAIMS PAID

                                                                          PAYEE ID                  MCD
                                                                          NPI
                                                                          PAYMENT NUMBER
                                                                          PAYMENT DATE


  --ICN--      PATIENT NUMBER   MRN       SERVICE DATES      BILLED AMT      OTH INS AMT    COPAY AMT       PAID AMT
                                          FROM    TO        ALLOWED AMT    SPENDDOWN AMT   CO-INS CB      OUTPAT DED

MEMBER NAME:                                MEMBER NO.:

                    SERVICE DATES ALLW UNITS RENDERING PROVIDER        PA NUMBER
PROC CD  MODIFIERS  FROM    TO     COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT
 S5150  U7 UA U9

EOBS    001   0952  9806
REMARKS 001   M53

BILLED AMOUNT    SUM OF ARCS    = PAID AMOUNT

  --ICN--      PATIENT NUMBER   MRN       SERVICE DATES      BILLED AMT      OTH INS AMT    COPAY AMT       PAID AMT
                                          FROM    TO        ALLOWED AMT    SPENDDOWN AMT   CO-INS CB      OUTPAT DED

MEMBER NAME:                                MEMBER NO.:

                    SERVICE DATES ALLW UNITS RENDERING PROVIDER        PA NUMBER
PROC CD  MODIFIERS  FROM    TO     COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT
 S5125  U7 UA

EOBS    001   9806
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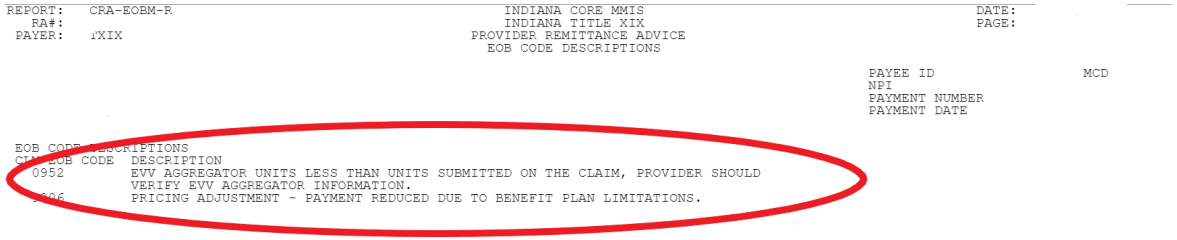

```
REPORT:   CRA-EOBM-R                          INDIANA CORE MMIS                              DATE:
   RA#:                                       INDIANA TITLE XIX                              PAGE:
 PAYER:   IXIX                             PROVIDER REMITTANCE ADVICE
                                             EOB CODE DESCRIPTIONS

                                                                          PAYEE ID                  MCD
                                                                          NPI
                                                                          PAYMENT NUMBER
                                                                          PAYMENT DATE


EOB CODE DESCRIPTIONS
CLM EOB CODE   DESCRIPTION
  0952         EVV AGGREGATOR UNITS LESS THAN UNITS SUBMITTED ON THE CLAIM, PROVIDER SHOULD
               VERIFY EVV AGGREGATOR INFORMATION.
  9806         PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO BENEFIT PLAN LIMITATIONS.
```

Look specifically for **0950/0951** or **0952** for EVV-related issues

Checking Claims on RA

```
  --ICN--       PATIENT NUMBER    MRN          SERVICE DATES      BILLED AMT       OTH INS AMT     COPAY AMT         PAID AMT
                                                FROM    TO       ALLOWED AMT     SPENDDOWN AMT    CO-INS CB       OUTPAT DED

MEMBER NAME:                                                 MEMBER NO.:
                                              020322 020922       1,315.12             0.00           0.00         1,315.12
                                                                  1,315.12             0.00           0.00             0.00

                     SERVICE DATES ALLW UNITS RENDERING PROVIDER          PA NUMBER
PROC CD  MODIFIERS   FROM   TO     COPAY AMT  BILLED AMT   ALLOWED AMT   PAID AMT
 T2016   U7 U5       020322 020922   52.50
                                        0.00     1,315.12     1,315.12      1,315.12

EOBS     001    0952  9070   9806   9918
ARCS     001    94              0.01  45            -0.01
REMARKS  001    M53

BILLED AMOUNT  - SUM OF ARCS     = PAID AMOUNT
      1,315.12              0.00            1,315.12
```

Claim EOB Information

Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Pay	0952	EVV AGGREGATOR UNITS LESS THAN UNITS SUBMITTED ON THE CLAIM, PROVIDER SHOULD VERIFY EVV AGGREGATOR INFORMATION.

Upcoming Activities
August 2022 - December 2022

Upcoming Activities

- Attestation form to confirm understanding of compliance
- Additional EVV virtual townhalls (September and November)
- In-person session at IHCP Works annual seminar
- Reminder notifications (IHCP banner articles)
- Direct phone call outreach

Points of Contact for Assistance

Specific Contact	Method
Gainwell Provider Relations (Virginia Hudson)	inxixevv@gainwelltechnologies.com
Tier 1 Sandata Support	800-457-4584, Option 5
Alternative Vendor Support	inaltevv@sandata.com Contact your EVV vendor
FSSA EVV Policy	evv@fssa.in.gov

Questions?

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning

Satisfaction Survey Reminder

Your participation in the brief 2-minute survey is requested.

INARF FY2023 Salary Survey

- The INARF Salary Survey will launch on Friday, Aug.12
- CEOs will receive both the CEO Survey and the Staff Survey
- The Staff Survey will also be emailed to those designated in the INARF Membership Directory for Human Resources or Financial Management
- Initial deadline will be Friday, Sept. 2
- Thank you in advance for your organization's participation in both Surveys
- Results are anticipated to publish by Mid-November

Contribute to the PAC

INARF PAC

2022 PAC Contributors are invited to the August 26 INARF PAC Legislative Reception.

Your contributions to the INARF PAC are a critical part of INARF's legislative advocacy efforts. They are used to support elected officials who serve as champions of the provider community. Please consider supporting the INARF PAC today.

For more information and to contribute, scan the QR code or visit: www.INARF.org/INARF-PAC

Sponsorship Recognition

Alicia M. Boyd, CPA
Professional Corporation

CPAs / ADVISORS
blue

Bradley Associates
Healthcare Advisors and CPAs

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Thank you!

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