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PRESENT.:

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Presenter:

Mary Thornton, BSRN, MBA
National Expert and Trainer

When:

Tuesday, March 4, 2008
8:30 a.m. to 4:30 p.m.

Where:

Centennial Hall in Juneau

No Fee:

However, you must be registered to attend. Please complete the registration form below and email to Katiec@ivs.org or fax to Katie Crossley at 789-2106

Jointly sponsored by the Alaska Association of Homes for Children (AAHC) and the Alaska Behavioral Health Association (ABHA)

Registration Form

Medicaid Behavioral Health - Audits, Federal Changes, Corporate Compliance Training by Mary Thornton on March 4, 2008.

NAME OF AGENCY:		
Persons Attending Training	Title	Email Address

Email to Katiec@ivs.org or fax to Katie Crossley at 789-2106

Mary Thornton & Associates, Inc.

Behavioral Health Collaborative Solutions

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Are You 'Audit Proof"?

Download these important and timely articles by Mary Thor

Protecting Yourself from an Adverse Federal Audit: Mary Thornton, 2

OIG Work Plan for Fraud and Abuse Focuses on Behavioral Health: Mary Thornton, 2005

Mary Thornton & Associates, Inc. (***MTA***) is a healthcare consulting firm that specializes in operational solutions for behavioral health organizations nationwide. Recently *MTA* has focused on the revenue cycle within organizations that are undergoing significant change or need to reorganize and refocus management and staff attention on the development of diversified revenue sources. Using the organization's current revenue cycle as a baseline, *MTA* assists organizations to:

- Reduce the time from client referral to cash receipts;
- Redirect staff efforts towards billable activities with a focus on increasing quality of care
- Increase staff productivity
- Implement internal controls on revenue generation to ensure compliance with regulation and law
- Develop efficient and effective third party billing and reimbursement departments
- Implement practice management techniques that enhance service delivery and revenue generation focusing on the individual practices of different employee groups - medical staff, clinical staff, community-based workers
- Train staff on a variety of subjects that increase the power of the revenue cycle to positively impact the organization's bottom line including – marketing, corporate compliance, practice management; third party billing and reimbursement with a specialty in the federal health care programs, mental health rehabilitation services including delivery systems, documentation, service fidelity
- Increase the effectiveness of senior management in their work to develop flexible, strong, and financially viable organizations.

MTA believes that behavioral health can effectively use tools developed by the larger business community to implement a strong business-focused infrastructure. These infrastructures can better support the implementation of best practices, clinical models and the continuing innovation which are critical to behavioral health's future. MTA also believes that management needs to refocus their attention on payer requirements and regulations and to use those rules to support revenue maximization in a high quality environment.

Mary Thornton, BSRN, MBA, is the president of *MTA* and its founder. She is a talented and engaging consultant and trainer with significant expertise in mental health rehabilitation reimbursement systems, medical necessity and documentation, coding and reimbursement, and corporate compliance in behavioral healthcare. She combines a Bachelor's in Nursing with an MBA to assist behavioral healthcare service systems and providers in designing efficient, high quality services and programs. Ms. Thornton was a member of the consulting teams that assisted in the conversion to rehabilitation option for the states of Illinois, Georgia, Connecticut,

and the District of Columbia. She was also the lead consultant on compliance issues for the state of Ohio in its SOQIC project designed to further operational efficiency through standardized documentation and training in medical necessity and rehabilitation option services. Ms. Thornton is the author of a number of publications on corporate compliance including *Ahead of the Game: Corporation Compliance for Behavioral Health* and on HIPAA including the *The HIPAA Handbook: What Community Behavioral Healthcare Organizations Need to Know about HIPAA*. These books and others were published by the National Council of Community Behavioral Healthcare. Ms. Thornton is also published in a number of behavioral healthcare journals where she contributes articles on compliance, coding and reimbursement, HIPAA, and other topics. She is also a nationally recognized trainer and a featured speaker for many state and national associations of provider agencies.

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Behavioral Health Services

The New Medicaid Environment

Presented by Mary Thornton

Sponsored by:

Alaska Behavioral Health Association &
Alaska Association of Homes for Children

Medicaid

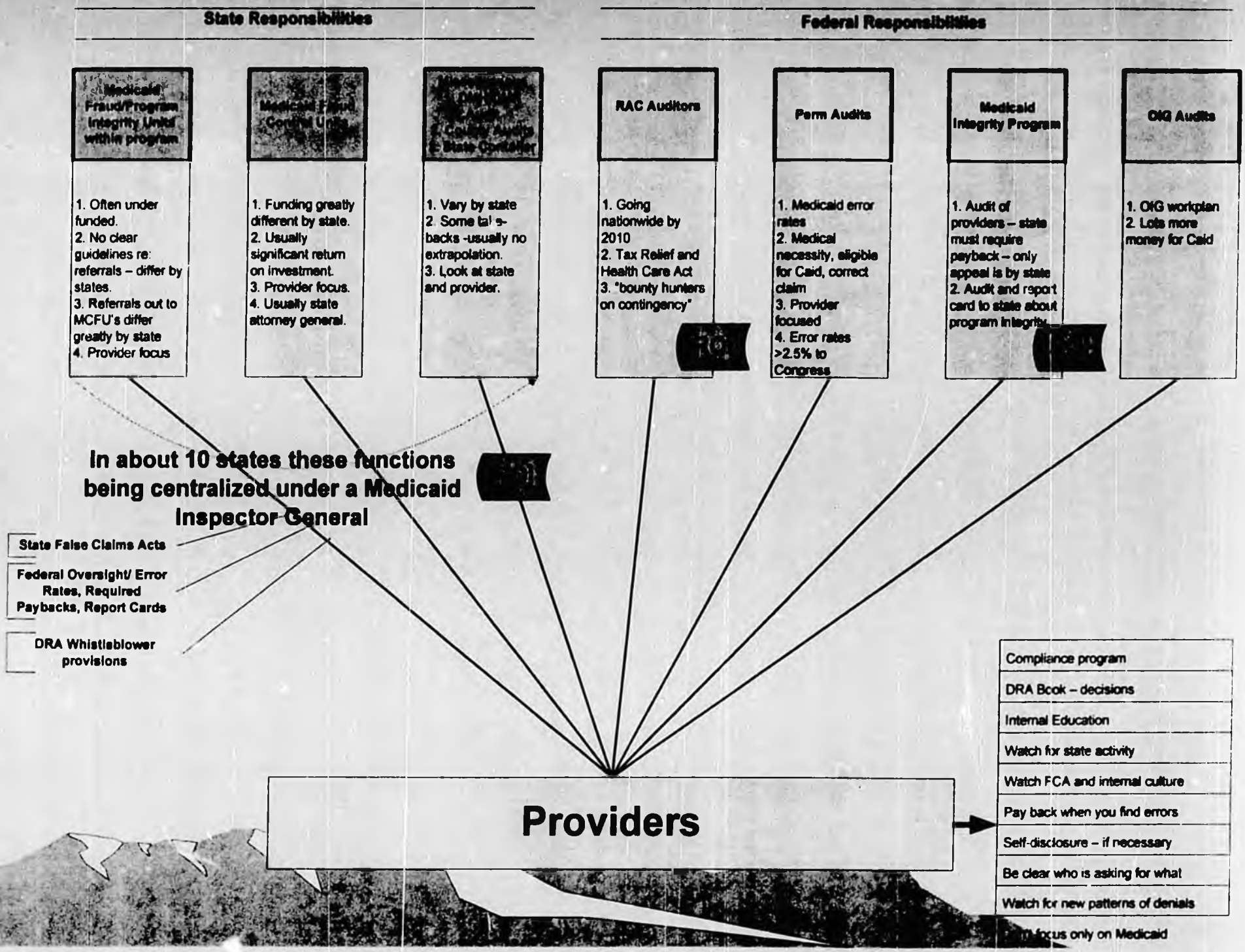
- Shared cost federal and state
- Two opinions on quality and content of services
- Greater emphasis right now at federal level on cost savings
  - Narrower definitions
  - Medical model – health vs. wellness

Among the Federal Frustrations with Medicaid

- Fraud efforts are uneven
  - Laws do not exist to prosecute as Feds would like
  - Investment in investigating arms is inadequate given the risk
  - Rules are different in each state making national coverage decisions and enforcement appear to be difficult
  - Providers implementation of compliance efforts appear to be inadequate given audit findings
  - "Medicaiding" services and other financing schemes

I. New Auditors

- New landscape in federal oversight and provider requirements
- PERM: state focus
- DRA: state and provider focus
- RAC: bounty hunters
- Increase pressure on states to increase program integrity activities


State Responsibilities
Federal Responsibilities
Medicaid Fraud/Program Integrity Unit within program
Medicaid Fraud Control Unit
State Controller
RAC Auditors
Perm Audits
Medicaid Integrity Program
OIG Audits
1. Often under funded.
2. No clear guidelines re: referrals – differ by states.
3. Referrals out to MCFU's differ greatly by state
4. Provider focus
1. Funding greatly different by state.
2. Usually significant return on investment.
3. Provider focus.
4. Usually state attorney general.
1. Vary by state
2. Some tak s-backs -usually no extrapolation.
3. Look at state and provider.
1. Going nationwide by 2010
2. Tax Relief and Health Care Act
3. "bounty hunters on contingency"
1. Medicaid error rates
2. Medical necessity, eligible for Caid, correct claim
3. Provider focused
4. Error rates >2.5% to Congress
1. Audit of providers – state must require payback – only appeal is by state
2. Audit and report card to state about program integrity
1. OIG workplan
2. Lots more money for Caid
In about 10 states these functions being centralized under a Medicaid Inspector General
State False Claims Acts
Federal Oversight/ Error Rates, Required Paybacks, Report Cards
DRA Whistleblower provisions
Providers
Compliance program
DRA Book – decisions
Internal Education
Watch for state activity
Watch FCA and internal culture
Pay back when you find errors
Self-disclosure – if necessary
Be clear who is asking for what
Watch for new patterns of denials
Focus only on Medicaid

II. New Rules

- See the attached *NY Times* article
- Rehab Rule
- CM Rule
- Evidence-based Practices: CMS encyclical

Expected Outcome: Rehab Rule

- 150mm in savings in 2008
- 2.2 billion is savings from 2008 to 2012
- Primary savings to come from Medicaid not paying for inappropriate services and services that are "intrinsic" to other services and already being paid for by another party

Changes

- **Non-covered services:**
  - **Services that provided by non-medical program either as a benefit or as an administrative activity (e.g. case management), including services that are intrinsic elements of programs other than Medicaid.**
    - Therapeutic foster care
    - Packaged services furnished by foster care or child care institutions for a foster child
    - Adoption, family preservation, family reunification
    - Routine supervision and non-medical support by teacher's aides
  - **Habilitation services: individuals with mental retardation or related conditions**
  - **Recreational or social activities**
  - **Services provided to inmates**
  - **Services to residents of IMDs (Institutions for Mental Diseases)**
  - **Room and board**
  - **Services to those not Medicaid eligible**
  - **Services not to a specific individual**

Proposed Savings: Case Management Services

- Current costs: 2006 - $2.84 billion
- 1.28 billion over 4 years
- .37 billion in additional costs as programs in which case management is seen as an integral part take on their responsibilities
- Net 800,000,000 + in potential savings

Case Management Defined

- Direct assistance in gaining access to services
- "In the context of this regulation, it is the individual's access to care and services that is the subject of this management – not the individual."
- Redefined in Deficit Reduction Act –it was effective as of January 1, 2006.

Case Management and Targeted Case Management (TCM)

- New definition:
  - Assessment
  - Treatment planning
  - Referral and referral related activities
  - Evaluation and monitoring of plan

Case Management and TCM

- No monitoring and oversight of client activities
- No supplying services which are ordered in the underlying treatment plan

Excerpt: *CMS and The Evidence-Based Practices

Family Psychoeducation:

- "consultation with other family members can be a necessary part of planning and providing care to patients in need of psychiatric services. Consultation can, however, devolve to a point where it becomes a means of treating others rather than, or in addition to, the primary recipient. Medicaid would not reimburse for services provided to ineligible family members for treatment of their problems not related to the treatment of the Medicaid patient. In addition, Medicaid would not reimburse for family psychoeducation classes unless tailored specifically toward the Medicaid beneficiary."
- Definition CM and Rehab confirm this as well

*Center for Medicare & Medicaid Services

Excerpt: *CMS and The Evidence-Based Practices

Supported Employment:

- Medicaid is statutorily excluded from the provision of vocational services.
  - "Therefore, under the State Plan, Medicaid cannot pay for the employment of an individual. Similarly, payment may not be made for employment assessments or ongoing support to maintain employment (emphasis added) except under an HCBS waiver. However, Medicaid can pay for the medical services that enable an individual to function in the workplace."

III. Creating Silos

- Braiding not integrating
- Establishing separateness of systems – in new CM rule
  - Child Welfare
  - Probation/Parole
  - School: more limited

Case Management Silo

- Integral components/duplicate services:
  - Foster Care: includes case planning, case management activities
  - Child Welfare/Protective services: includes for some children under protective orders same as above – child welfare services are considered to be the "direct services" of the CW system and not Medicaid CM
    - This includes a prohibition on paying for contractors of the CW system who are providing CM services because they are fulfilling the obligations of the CW system.

Case Management Silo

- Integral components/duplicate services:
  - Parole and Probation: functions exist independent of the Medicaid program
    - No parole officers or contractors of the justice system for TCM
    - No services that are in effect part of the administration of the State's parole or probation system

Case Management Silo

- Integral components/duplicate services:
  - Public Guardianship
    - State or locally administered and independent of the Medicaid program
    - You can assist decision-makers but you are not the decision-maker
    - Cannot replace the function or fund the function
    - My opinion: this includes rep payee work

Case Management Silo

- Integral components/duplicate services:
  - Special Education
    - Exception made for CM and other services ordered under an IEP or IFSP – case manager must be Medicaid eligible provider.
    - IFSP requires a service coordinator from the beginning if the infant or toddler has a disability – these can be Medicaid CM/TCM services
    - Cannot cover administrative functions under the Individuals with Disabilities Education Act (IDEA), e.g. calling meetings, reports, writing plan

IV. Reasserting Old Rules

- Exclusive Benefit: Family Treatment
- Specific and effective treatment: Parenting
- Medical necessity: Recovery Goals?
- IMD Issues

IMD (Institutions of Mental Diseases) Defined

- Section 1905(i) of the Social Security Act (Act) and 42 Code of Federal Regulations (CFR)
- § 435.1009 define an IMD as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Psychiatric hospitals (including State-operated and private psychiatric hospitals) and inpatient psychiatric residential treatment facilities with more than 16 beds are IMDs.

Medicaid Funding

- Regulations found at 42 CFR §§ 435.1008 and 441.13 preclude paying FFP (federal financial participation) for any services to residents under the age of 65 who are in an IMD, except for inpatient psychiatric services provided to individuals under the age of 21 and in some instances those under the age of 22.

Medicaid Funding

- Medicaid will pay per diems for room and board only for those inpatient psych facilities that are PRTFs.
  - Certain staffing and facility requirements
  - Licensing
  - JCAHO accreditation
- Residential treatment rate setting concerns – how developed, is room and board sufficiently covered by other funds.

Virginia/New York

- Medicaid exception for 21 and under is for inpatient psychiatric services only – not other medical or dental services
- NY Appellate Court seem to suggest leniency in application of this rule by suggesting auditors could have denied all non-psychiatric services provided in the hospital but instead chose to deny only those outside of hospital

Georgia: Child Caring vs. RTC vs. IPRT

- Developed set of guidelines for children's providers
- Last edit in July 2007
- Based on their reading of distinct part hospital guidance, nursing facility guidance, the experience of Illinois
- Many and big disclaimers – no guarantee

V. Financial/Payment Issues

- Unbundling

Payment: Case Management

- "a state cannot employ a methodology or rate that results in payment for a bundle of services"
  - Per diem- no
  - Monthly -no
  - Weekly no
- Why: paying for anticipated not actual services; requires a great deal of federal oversight to make sure the bundled rate is reasonable.
- Yes to: 15 minute or less units of service – do understand that many case management activities are very brief.
  - Not clear if a rounding convention must be used or if minutes can be counted or if anything that is 15 minutes or less is ok.

What Needs to be Done

- Awareness at state level of potential impact
  - Proactive change
- Provider support:
  - Rewriting manuals
  - Technical assistance: Compliance, Service Deiivery, Documentation
- Legislative advocacy

February 24, 2008

Governors of Both Parties Oppose Medicaid Rules

By ROBERT PEAR

WASHINGTON — Governors of both parties strongly objected on Saturday to a half-dozen new federal Medicaid regulations that they said would shift billions of dollars in costs to the states, forcing them to consider cutbacks in services.

The rules, scheduled to take effect in the next few months, would reduce federal payments for public hospitals, teaching hospitals and services for the disabled, among others.

State officials voiced their concerns as they arrived here for the winter meeting of the National Governors Association.

Federal health officials said the new rules were needed to end creative financing techniques that states had used to obtain excessive amounts of federal Medicaid money.

But governors said the Bush administration was unilaterally reshaping Medicaid in ways that would harm some of their most vulnerable citizens. Moreover, they said, the rules are taking effect at a time when the national economic slowdown is cutting into state tax revenues.

"Governors strongly oppose the changes," said Gov. Jim Douglas of Vermont, a Republican who is chairman of the association's Health and Human Services Committee. "The timing could not be worse."

One of the rules would ban the use of federal Medicaid money to help pay for the training of doctors, a use that has been allowed since the inception of Medicaid more than 40 years ago. Another would set new limits on Medicaid payments to hospitals and nursing homes operated by states, cities, counties and other units of government.

A third rule would limit Medicaid coverage of rehabilitation services for people with disabilities, including serious mental illnesses.

Federal officials estimate that the rules will save the federal government $15 billion over five years. But that figure may be low. California alone says it could lose $12 billion over five years.

Congress delayed some of the rules last year, but they will soon take effect unless Congress intervenes again.

Gov. Arnold Schwarzenegger of California, a Republican, said the rule changes "would effectively end the federal government's participation in many crucial components of the Medicaid program."

Dr. Rhonda M. Medows, commissioner of the Georgia Department of Community Health, said: "We understand the need for financial safeguards, but these rules, taken together, would have a tremendous adverse impact. They would undermine the health care safety net for the entire state of Georgia, reducing federal Medicaid payments for hospitals, nursing homes and school clinics."

The National Conference of State Legislatures joined governors in criticizing what it described as "the regulatory activism" displayed in the new rules.

The federal government and the states share the cost of Medicaid, which provides health insurance to more than 60 million low-income people, including 30 million children.

Dennis G. Smith, director of the federal Center for Medicaid and State Operations, said the rules were needed to "protect the fiscal integrity of the Medicaid program." Since 2003, he said, federal officials have persuaded 30 states to end "questionable Medicaid financing arrangements." The purpose of such arrangements is to maximize the use of federal money while holding down the use of state and local revenue.

Although the most blatant problems have been corrected, the administration says, many states still use federal Medicaid money for purposes unrelated to Medicaid.

"We believe that paying for graduate medical education is outside the scope of Medicaid's role, which is to provide medical care to low-income people," Mr. Smith said. "There is no explicit authorization under the Medicaid statute to subsidize the training of physicians."

Robert M. Dickler, chief health care officer at the Association of American Medical Colleges, said, "It's a little surprising that the federal government would just now discover that there's no legal basis for the Medicaid payments it's been making for medical education since 1965."

Stan Rosenstein, the Medicaid director in California, said the payments were justified because "interns and residents provide a tremendous amount of care to Medicaid beneficiaries."

The federal government says this rule would save $1.8 billion over five years. But New York, which trains 15 percent of the nation's doctors, says it would lose more than that alone. State officials are also concerned about a rule that would eliminate federal contributions for a whole category of public spending on health care for the poor — specifically, spending

by autonomous units of local government like the Denver Health and Hospital Authority.

"As a result of this rule, we will lose $60 million a year," said Dr. Patricia A. Gabow, chief executive of the Denver agency, which operates a 477-bed public hospital, the city's public health department and its ambulance service. "We were part of the city government for more than 130 years. In 1997, we became an independent governmental entity, but we don't have taxing authority. So we don't qualify as a public provider, and we can't draw down critically important subsidies for services we provide to the entire community."

Larry S. Gage, president of the National Association of Public Hospitals, said the rule's importance went far beyond Medicaid because it would compromise the ability of public hospitals to provide vital services like trauma care and burn treatment.

New York City Health and Hospitals Corporation, the largest municipal health care system in the country, which gets 60 percent of its budget from Medicaid, said the rules would have "a potentially devastating impact" and could force cutbacks in services.

A group of 17 states, including Connecticut, Michigan and New Jersey, told the administration that the new restrictions were "simply awful public policy." Senators Jeff Bingaman, Democrat of New Mexico, and Elizabeth Dole, Republican of North Carolina, are fighting the rule on public hospitals.

The rule "would have a devastating effect on North Carolina's Medicaid system, costing our hospitals hundreds of millions of dollars annually," Mrs. Dole said.

The Medicaid rules were overshadowed last year by a battle over insurance for children.

"We can have a legitimate discussion about expanding the Children's Health Insurance Program," said Governor Douglas of Vermont. "But the Medicaid rules are different. They renege on commitments already made."

In Vermont, Mr. Douglas said, "we've come to rely on Medicaid to help pay for special education and other services to children with disabilities."

Medicaid is a crucial part of the foundation on which many states were planning to build coverage for the uninsured.

Deborah S. Bachrach, a deputy commissioner in the New York State Health Department, said, "The new Medicaid rules make it difficult to pay for current programs and nearly impossible to expand coverage to all."