Department of HUMAN SERVICES

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

February 6, 2019

W. Charles Smithson
Secretary of Senate
State Capitol
LOCAL

Carmine Boal
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Smithson and Ms. Boal:

Enclosed please find attached the report to the General Assembly relative to the Medicaid Small Dollar Audit Report.

This report was prepared pursuant to the directive contained in 2018 Senate File 2418.

Please feel free to contact me if you need additional information.

Sincerely,

Mikki Stier
Deputy Director

MS/jh

Attachment (1)

Department of
HUMAN SERVICES

Medicaid Small Dollar Claims Audit Report

February 2019

Introduction

Health Services Advisory Group, Inc. (HSAG) and Public Consulting Group, Inc. (PCG) were hired to conduct a study on claim reimbursements to Long-Term Services and Supports (LTSS) providers pursuant to Iowa Senate File 2418, Division XXV, Section 128 Medicaid Program Administration, 3.c, and authorized under contract MED-16-012 between HSAG and the Iowa Department of Human Services.

The study focused on payments made by two Medicaid Managed Care Organizations (MCOs):

- Amerigroup Iowa, Inc. (Amerigroup)
- UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare)

The study was limited to LTSS claims less than or equal to $2,500 with dates of service between January 1, 2018, and March 31, 2018. For this reason, AmeriHealth Caritas Iowa, Inc. is not included in the study, as they withdrew from the Iowa Medicaid Managed Care program on November 30, 2017.

Key Personnel

Below is a listing of the key personal and their roles on this engagement.

- Project Lead: Garrett Abrahamson, PCG
- Supervising Manager: Jim Waldinger, PCG
- Lead Analysts: Corinne Willis, PCG and Jyothi Sarabu, PCG
- Contract Oversight: Gretchen Thompson, HSAG

Key Determination

The predominant methodology used by both MCOs to pay for LTSS services was a charge-based methodology. As such, the onus is on the provider to bill the correct, contracted rate for the service rendered in order to receive the correct reimbursement.

Dataset

The Iowa Medicaid Enterprise (IME) provided PCG with a dataset of claims with dates of service between January 1, 2018 through March 31, 2018. Pursuant to the legislation requesting this study, the dataset was limited to LTSS claims less than or equal to $2,500. The dataset contained 667,566 claim (service) lines.

The IME defines LTSS services as those services that help Medicaid members "maintain a good quality of life in settings such as their home or, if needed, in a facility."[1] Services are intended to help people reach the highest degree of independence possible. For the purposes of this study, the IME identified LTSS services by procedure code that ranged from Day Habilitation and Comprehensive Community Support Services to Personal Care and Homemaker Services. PCG's first step was to limit the dataset to paid claims as defined by the Claim Status field in Table 1:

Value	Description	Value	Description
A	Tape Billing Cycle	H	Held
B	In Process	I	To be Paid
C	Suspended	K	To be Denied
D	Suspense Ready to Process	N	Paid
E	Suspense to be Deleted	P	Denied
F	To be Suspended (CR/Adjust)	S	Susp-To be Deleted

Table 1: Claim Status Codes

PCG then limited the dataset to the final disposition of paid claims. When a claim is adjusted, the original claim is credited, and a new instance of the claim is paid (or denied), as appropriate. For this analysis, PCG reviewed only the final disposition of a paid claim.

The resulting dataset included 517,155 service lines across 53 procedure codes (126 unique procedure-modifier combinations). Many of these services were used infrequently, and so the study was limited to service codes that accounted for at least one percent of the overall volume. The following table lists services that accounted for less than one percent of the overall volume.

T2031	S5136	T2003	T2036	H2025	H2016	H2021	S5102	S5161	S5135	S5120
A0130	T1004	H0046	T1003	T2018	T1017	S5101	T2037	T1031	H0036	T1021
T2025	H2019	T1016	T1002	S9124	H0037	S5160	S5105	S9123	T1030	S5199
T2029	S5165	97802	S9122	97803	H2011	T2039	96154			

Table 2: Low Volume Services

The remaining Top 12 codes accounted for 94.8 percent of the unit volume, and produced 40 unique procedure-modifier combinations, as detailed in Table 3:

Procedure Code	Modifiers	Procedure Code Description
T1019	U3, U5, NULL	Personal Care Services
H2015	U3, HI, NULL	Comprehensive Community Support
S5150	UC, U3, NULL	Unskilled Respite Care, not Hospice; per 15 minutes
S5125	U3, UF, UG, UH, NULL	Attendant Care Services
S5170	UF, UG, UH, UJ, NULL	Home delivered meals, including preparation; per meal
T2021	U2, U3, UC, NULL	Day Habilitation-15 Minutes
T1005	U3, NULL	Respite Care Services, up to 15 Minutes
H2023	U3, U5, U7	Supported Employment, per 15 minute
T2020	U1-U6, UC, NULL	Day Habilitation, Waiver; per diem
S5130	NULL	Homemaker service, nos; per 15 Minutes
S0215	HI, NULL	Non-Emergency Transportation per Mile
T2015	NULL	Habilitation, Prevocational per Hour

Table 3: Top 12 Procedure-Modifier Combinations

The listing of modifiers above is used to indicate the level of care required by an enrollee or the time of day that the services are performed. Unlike traditional medical settings where modifiers may be more informational, modifiers for LTSS services are often vital to understanding the reimbursement for a service.

For instance, the IME has published the *Home and Community Based Services Intellectual Disability Waiver Tiered Rates Fee Schedule*. On that fee schedule is "Day Habilitation, Waiver; per diem (T2020)," which contains six different rates, with increasing levels of care (and, therefore, reimbursement), where the highest level of care is reimbursed at 73 percent more than the lowest level of care. The disparity amongst the reimbursement rates for procedure code T2020 by modifier is detailed in Table 4.

Procedure Code	Modifier	Published Rate on IME Fee Schedule
T2020	U1	$67.81
T2020	U2	$71.15
T2020	U3	$81.03
T2020	U4	$82.18
T2020	U5	$95.70
T2020	U6	$117.03

Table 4: Published Rates for Procedure Code T2020

Analysis

Charge-Based Reimbursement

Upon the initial review of paid claims data, PCG identified that more than 90 percent of claim lines were paid using a charge-based reimbursement methodology. Under this methodology, a service/procedure is reimbursed according to the rate billed by the provider, and not a fee schedule established by the payer. This shifts the responsibility to the provider to bill the correct contracted/negotiated rate for the service rendered.

As an example, a provider is contracted to render a service for $5.00 with one MCO and $5.50 with the other. The provider submits all of their claims billing $5.00 per service. Under a charge-based reimbursement methodology, that provider will receive $5.00 and will be underpaid by the second MCO. Conversely, if the provider always bills at the higher rate, the provider will receive $5.50 and will be overpaid by the first MCO.

The example of procedure code T2020 from the prior page further illustrates charge-based reimbursement discrepancies. PCG found instances where claims were billed with a U2 modifier, but at the U1 ($67.81) or U3 ($81.03) rate. Due to charge-based reimbursement, those claims were paid at the billed rates, which differed from the published fee schedule ($71.15); underpaid in the case of billing at the U1 rate and overpaid in the case of billing at the U3 rate.

We reviewed each of the 40 procedure-modifier combinations that comprised the Top 12 and conducted a frequency analysis of the unit rates of reimbursement. We then compared the rates of reimbursement to the published rate, where applicable, for that procedure-modifier combination. In reviewing the data, we identified two distinct patterns, both of which are supported by the charge-based reimbursement methodology.

Subset 1

In one subset of the procedure codes reviewed, we consistently found that the most frequently billed (and, therefore, reimbursed) rate was the rate published on the fee schedule.

We again turn to our example of T2020 to illustrate the consistency between billed/reimbursed rate and the published fee schedule. Across the various modifier combinations, the published rate was the same as the billed/reimbursed rate more than 97 percent of the time as outlined in Table 5 below:

Procedure Code	Modifier	Frequency Reimbursement = Published Rate
T2020	U1	99.01%
T2020	U2	97.47%
T2020	U3	99.22%
T2020	U4	98.89%
T2020	U5	98.58%
T2020	U6	99.72%

Table 5: Frequency of Reimbursement for Procedure Code T2020

Subset 2

Another subset of the codes reviewed appeared to have customized/negotiated rates by provider. This subset includes services such as Home Health Services (T1019) and Comprehensive Community Support Services (H2015). This subset of claims was also predominately paid using a charge-based reimbursement methodology. For instance, Home Health Services and Comprehensive Community Support Services were the two most frequently billed services in the Top 12, and the percentage of claim lines paid at billed rates was 97 percent and 98 percent, respectively

In this second subset, there was a much larger spread of rates amongst providers since the rates appear provider-specific. At the same time, however, claims were billed (and, therefore, reimbursed) consistently by individual providers. That is, providers typically billed the same rate for the service, even though that rate varied from other providers.

Conclusion

In reviewing three months of LTSS claims, accounting for nearly eight million units of service, we identified the predominant reimbursement method for these services as being charge-based. This methodology requires that providers bill the correct amount in order to receive the appropriate reimbursement.

Medical billing is complex. There are various procedure codes with different modifiers indicating level of care and time of day. The complexities are compounded when a contracted rate between a provider and an MCO differs from the contracted rate between that same provider and another MCO. Further, both contracted rates could

differ from the published fee schedule. Given this complexity, we recommend the following:

Develop and maintain a comprehensive and centralized fee schedule for LTSS. To increase consistency in payment for LTSS services, a comprehensive and centralized fee schedule should be developed. Today, rates are spread across multiple fee schedules. In many cases, there is not a published rate for procedure-modifier combinations.

Implement the comprehensive and centralized fee schedule. Once a comprehensive and centralized fee schedule is developed, payment based on that fee schedule can be more easily implemented.

Educate providers on reimbursement methodology and the impact of billed charges. Medical billing is complex. For this reason, provider education is vital to a provider's success in understanding reimbursement.

About the Organizations

Health Services Advisory Group, Inc. (HSAG)

HSAG is a multi-state Quality Innovation Network-Quality Improvement Organization (QIN-QIO), External Quality Review Organization (EQRO), and End-Stage Renal Disease (ESRD) Network contractor that serves approximately 25 percent of our nation's Medicare population, 46 percent of our nation's Medicaid population, and twenty percent of our nation's dialysis population.

Public Consulting Group, Inc. (PCG)

Public Consulting Group, Inc. (PCG) is a leading public sector management consulting and operations improvement firm that partners with health, education, and human services agencies to improve lives. Founded in 1986 and headquartered in Boston, Massachusetts, PCG has over 2,000 professionals in more than 50 offices around the US, in Canada and in Europe. PCG's Health practice offers in-depth programmatic knowledge and regulatory expertise to help state and municipal health agencies respond to regulatory change, improve access to health care, maximize program revenue, improve business processes, and achieve regulatory compliance. Using industry best practices, PCG's Health team helps organizations deliver quality services with constrained resources to promote improved client outcomes.