HMS BACKGROUND

- Leading healthcare cost containment firm serving 40 Medicaid agencies.
  - 23 years serving Medicaid community, staff of 750 across 23 office nationwide, with strong Medicaid policy and operational experience.
- Have been a contractor to VA DMAS since 1987
- Worked with various providers in Virginia since 1994
- Detailed understanding of First Health MMIS data

REVIEW OF DMAS PROGRAM GOALS

- Ensure that Virginia Medicaid Individuals receive:
  - appropriate behavioral and community mental health services
  - in the appropriate setting

- Ensure that services receive by Virginia Medicaid individuals are performed in accordance with:
  - Federal and state guidelines
  - Guidelines set forth in the Medicaid Manual

RFP BACKGROUND

VA DMAS has contracted with HMS to review eight behavioral & community mental health service levels:

- ✓ Crisis Intervention
- ✓ Crisis Stabilization
- ✓ Intensive In-Home Services
- ✓ Intensive Community Treatment
- ✓ Mental Health Case Management
- ✓ Mental Health Skills Building
- ✓ Therapeutic Day Treatment
- ✓ Psychosocial Rehabilitation

Ensure Medicaid dollars used toward provision of appropriate services to this population
Assist DMAS to identify providers who may benefit from additional provider training.

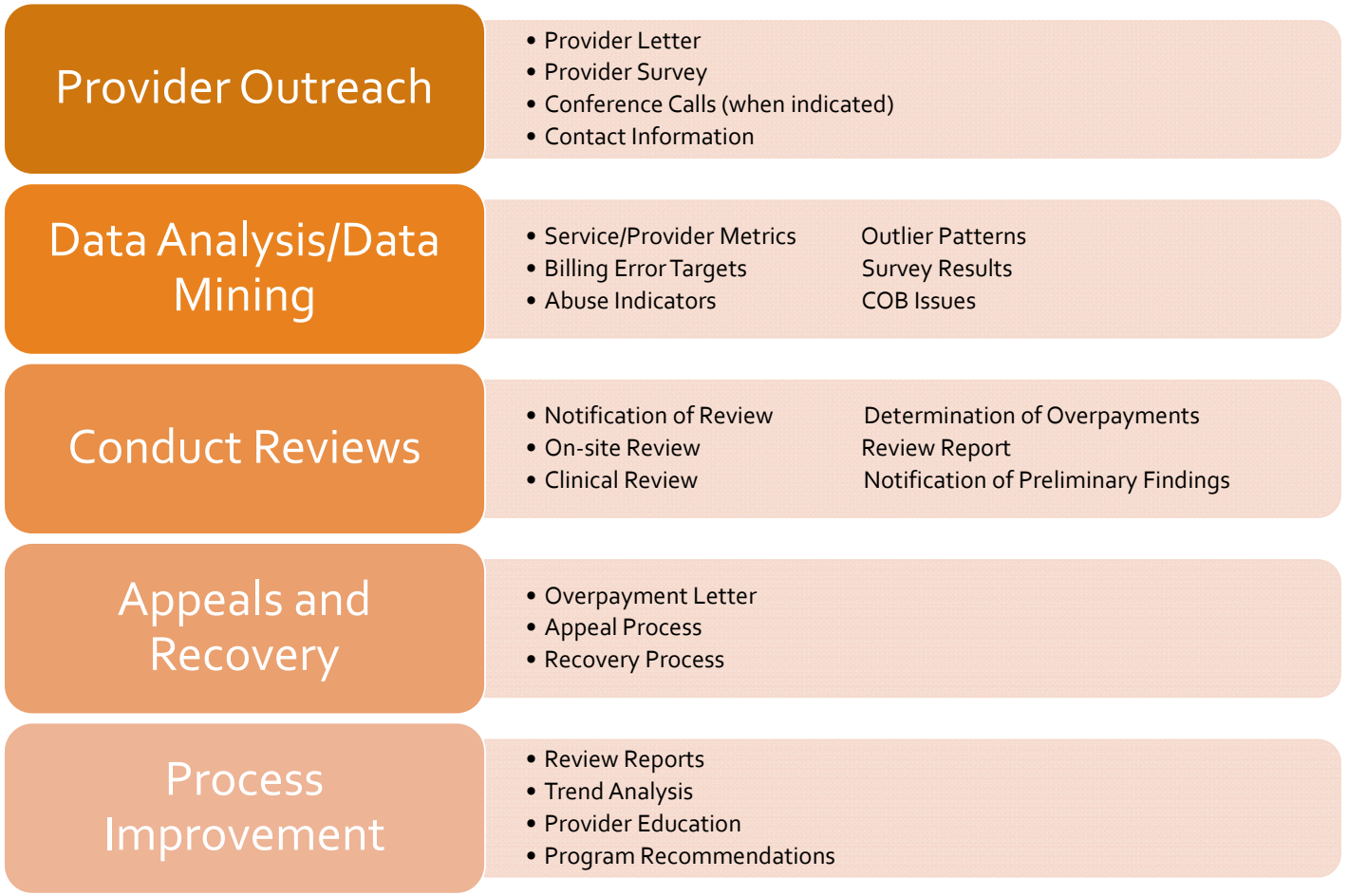
REVIEW OBJECTIVES

- Reviews performed within established DMAS guidelines.
  - "Mimic" existing DMAS review process procedures, as much as possible

- Notify the provider and DMAS if review findings identify overpayments that require recovery efforts by DMAS.

- Report review findings to facilitate provider education/training
  - Provider education to change behavior and avoid errors going forward
  - Review of specific provider errors
    - Corrective action plan, if warranted

Overview of HMS Review Process



PROVIDER OUTREACH

Provider Survey

- *Survey Goals/Objectives:*
  - To allow DMAS and Review Team to better understand the providers who provide these services to the Medicaid population
  - To provide a mechanism to allow providers to submit feedback about upcoming reviews, concerns.

- *Provider's Rule:*
  - Fill/return out brief, easy-to-fill out survey
  - Participation encouraged

- *Content of Survey:*
  - Demographic questions
  - Open ended questions intended to solicit provider feedback, review preferences.

DATA ANALYSIS/ DATA MINING

- *Service/Provider Metrics*
  - Billing per patient
  - Patients per provider
- *Outlier Utilization*
  - Units/month vs. peers
  - Patients/month vs. peers
  - Units/patients/month vs. peers
- *Billing Patterns*
  - Excess unit claims
  - Billing for dates of service in facility/deceased
  - Medicare COB opportunities
  - Referral targeting

SELECTION OF PROVIDERS FOR REVIEW

- Any licensed participating provider enrolled with Virginia Medicaid may be reviewed for any of the eight service levels:
  - ✓ Crisis Intervention
  - ✓ Crisis Stabilization
  - ✓ Intensive In-Home Services
  - ✓ Intensive Community Treatment
  - ✓ Mental Health Case Management
  - ✓ Mental Health Skills Building
  - ✓ Therapeutic Day Treatment
  - ✓ Psychosocial Rehabilitation
- Total of at least 70 providers selected for review from January 2016 – December 2016.

SELECTION OF CASES/CLAIMS FOR REVIEW

- Targeted review of claims for period DOS SFY 2013 & 2014 (for providers selected)
  - Review 30-50% of Medicaid claims within the respective service levels

CONDUCTING REVIEWS

- Provider Notification for Desk Reviews
  - Certified mail to specific individual
  - Letter will request specific individual and claim information
  - Specific return instructions provided
  - Provider is responsible for submitting requested documentation within 14 business days of individual of the medical record request

- Provider Notification for Onsite Reviews
  - Certified mail to specific individual
  - Review will occur no sooner than 14 business days from date of letter
  - List of individuals/claims selected for review available when team arrives on-site

- Process entails review of following documentation:
  - Provider credentials and licensure
  - Medical necessity
  - Progress notes
  - Services Rendered
  - Actual time spent with patient
  - Staff Qualification

- Review process is driven by Review Protocols/Error Matrix defined for each service level:
  - Consistent audit approach
  - Standardized data-gathering approach
  - Review Team approach