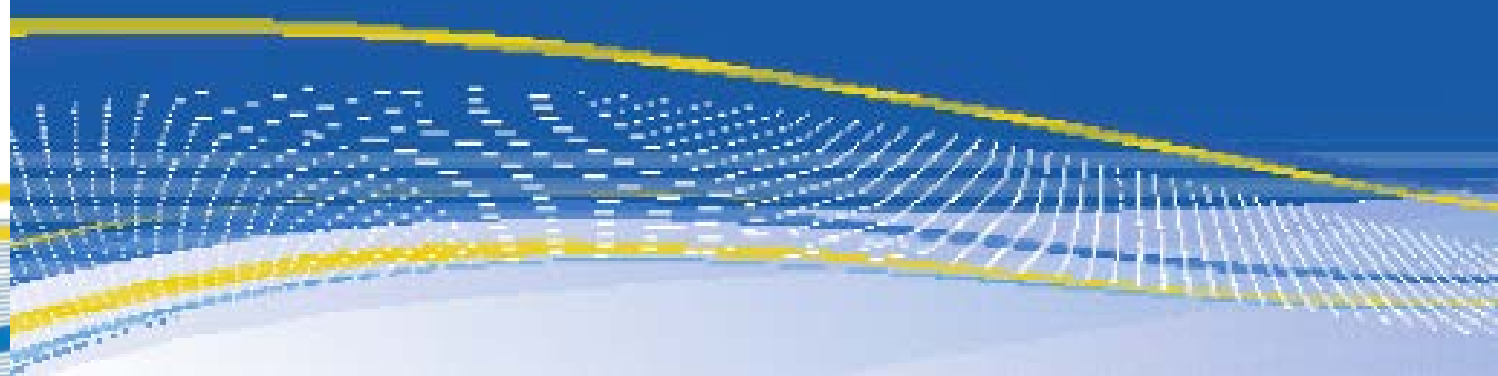




# Ensuring the Integrity of HCBS Payments: Billing Validation Methods



Division of Long Term Services and Supports  
Disabled and Elderly Health Programs Group  
Center for Medicaid and CHIP Services



# Training Objectives

- Review the “essential tests” for billings outlined in the 1915(c) Technical Guide.
- Identify billing validation strategies beyond traditional post-payment reviews.
- Explore documentation methods for billing validation in Appendix I-2-d.

# What is Billing Validation?

# Billing Validation

## What is Billing Validation?

- Per the 1915(c) Technical Guide, billing validation means “pre-payment and other processes that are designed to ensure that provider’s billing for waiver services meets **essential tests** and that only valid billings are included in the state’s claim for Federal Financial Participation (FFP).”
  - FFP refers to Federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services.
  - The specified percentage of program expenditures paid to states is called the Federal Medical Assistance Percentage (FMAP).
  - FMAP varies by state based on the economic condition of the state, e.g., per capita income.

# Billing Validation: Essential Tests

## What are the Three Essential Tests to Validate Billing?

### 1. The individual was eligible for the waiver on the date of service.

*(Level of Care assurance)*

- Did the individual meet the categorical (including level of care) and financial eligibility requirements on the date of service?
- Was the individual properly enrolled in the waiver program on the date of service?

### 2. The service billed was included in the individual's approved service plan.

*(Qualified Providers, Service Plan and Financial Accountability assurances)*

- Was the service billed of the type, scope, amount, duration and frequency specified in the approved service plan?
- Did the provider follow any and all applicable prior authorization requirements?

# Billing Validation: Essential Tests

## What are the Three Essential Tests to Validate Billing?

### 3. The services were provided.

*(Financial Accountability assurance)*

- Does the provider's documentation support the submitted claim (including the type, scope, amount, duration and frequency of the service)?
- Did the provider meet licensure, certification, screening and training requirements necessary to render the service?
- At an aggregate level, is it feasible / reasonable that the provider was able to deliver all of the services billed to the Medicaid program?
- Does the individual acknowledge that services were rendered?
  - Through case management visits, service plan review and/or monitoring.
  - For self-directed services, through timesheet approval and recordkeeping.

# Billing Validation

## Pre-Payment v. Post-Payment Billing Validation

### ➤ Pre-Payment

- Validation occurs *before* a provider is paid.
- Should be documented in **Appendix I-2-d** of the application.
- This training focuses specifically on pre-payment billing validation as an essential component of financial accountability.

### ➤ Post-Payment

- Validation occurs *after* a provider is paid.
- Should be documented in **Appendix I-1** of the Application.

# Billing Validation

## Pre-Payment v. Post-Payment Billing Validation

	Pros	Cons
Pre-Payment	<ul style="list-style-type: none"> <li>➤ Cost avoidance—money never leaves the waiver program.</li> <li>➤ Savings from avoided costs can go toward additional waiver slots or back into the state budget.</li> </ul>	<ul style="list-style-type: none"> <li>➤ More difficult to demonstrate return on investment (ROI)* because states can only measure cost avoidance rather than recoveries.</li> <li>➤ More proactive—states must be aware of changes in provider behavior and potential FWA schemes.</li> </ul>
Post-Payment	<ul style="list-style-type: none"> <li>➤ Easier to apply algorithms and identify potential overpayments.</li> <li>➤ Easier to demonstrate Return on Investment (ROI)* based on recoveries.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Low-cost, high-volume HCBS claims often means states must target large recoveries to make up for the cost of investigations.                             <ul style="list-style-type: none"> <li>• HCBS often have low recoupment yields.</li> <li>• Expensive appeals and settlements.</li> </ul> </li> </ul>

\* We define ROI as the benefit to the state resulting from an investment in a strategy. ROI is used to measure the financial impact of an initiative.



# Pre-Payment Billing Validation Strategies

# Eligibility Verification

- Eligibility verification refers to processes used to confirm an individual is eligible for Medicaid and is eligible to receive services under the waiver.

## Types of Eligibility Verification

- **Categorical Eligibility:** Individual meets Medicaid-specified groups or categories, such as children, older persons, or individuals with disabilities.
- **Level of Care (LOC) Eligibility:** Individual meets the minimum amount of need to receive services in an institutional setting, as defined under the State Plan.
- Oversight for Categorical and LOC eligibility determination should be discussed in **Appendix B** of the waiver application, including within the LOC quality assurance discussion. For example:
  - MMIS edits and business processes to automatically transition individuals when they no longer meet categorical eligibility (e.g., children who age out of a waiver).
  - Automated ticklers to remind evaluators of annual LOC redeterminations.
  - Method of and timeframe for tracking changes in LOC or service needs.

# Eligibility Verification

- **Financial Eligibility:** Individual's financial circumstance meets state qualification requirements, including:
  - Amount of countable income (income standard).
  - Amount of countable resources (resource standard).
- States use different methods for validating financial eligibility. For example:
  - **Asset** verification: Identify individuals with bank accounts exceeding program limits.
  - **Property** verification: Identify disqualifying asset transfers and property which must be included in calculation of assets.
  - **Residency** verification: Identify out-of-state residents and residents receiving Medicaid in another state.
  - **Income** verification: Identify individuals with income exceeding program limits or questionable income self-reporting.
  - **Household composition** verification: Identify changes in household composition affecting coverage levels.
- **Incarceration status** verification: Identify incarcerated recipients.

# Eligibility Verification

## ➤ **Manual eligibility verification**

- States require individuals to submit attestations or other documentation proving eligibility.
- States must implement methods of validating documentation. For example, manually verifying income with:
  - Social Security Administration
  - State Business Registries
  - State Employment Departments
  - Supplemental Nutritional Assistance Program (SNAP) Records

# Eligibility Verification

## ➤ Automatic eligibility verification

- Collect identifying information from individuals (e.g., name, date of birth, address) and use data matching to identify information individuals may have inadvertently omitted. For example:
  - Identify undisclosed accounts / assets using data from financial institutions across the nation.
  - Verify income using quarterly state wage data, federal tax information, Equifax and child support records.
  - Verify citizenship and immigration status with the Department of Homeland Security.
  - Use the Public Assistance Reporting Information System (PARIS) to check for enrollment in other state Medicaid programs.
- Can be designed to account for potential data entry errors (e.g., geographic proximity for an incorrect address).

# Eligibility Verification

## Considerations

- The Affordable Care Act and accompanying federal regulations (42 CFR §435.945(j), 457.380(j), 435.940-435.965 and 457.380) required states to submit a “Verification Plan” to CMS outlining their approaches to eligibility verification.
- Processes are generally uniform across a state Medicaid program.
- Having robust data management improves the state’s likelihood of:
  - Maintaining low eligibility error rates.
  - Reducing burden on individuals and eligibility staff.
  - Achieving administrative efficiency and potential cost savings.
- State eligibility requirements are often complex. Training staff is key to successful verification.

## Essential Test Met

- ✓ Individual was eligible for the waiver on the date of service

# Third Party Liability (TPL) Identification

- **TPL:** Per Technical Guide page 312, TPL is the Medicaid term used to refer to another source of payment for Medicaid-covered services provided to a beneficiary. Examples include, but are not limited to\*:
  - Medicare;
  - Long-term care insurance;
  - Group health plans;
  - Self-insured plans;
  - Pharmacy benefit managers;
  - Other state or Federal coverage programs (unless specifically excluded by law);
  - Court-ordered health coverage;
  - Settlements from a liability insurer; and
  - Worker's compensation.

*\*From Medicaid Third Party Liability & Coordination of Benefits website.  
<https://www.medicaid.gov/medicaid/eligibility/tpl-cob/index.html>*

# Third Party Liability (TPL) Identification

- Examples of TPL identification activities include:
  - Process and adjudicate Medicare crossover claims to ensure Medicare benefits are expended before Medicaid payment is made.
  - Matching between Medicaid and commercial insurance enrollment files and reclamation.
  - Data matching with public entities. For example:
    - Department of Defense;
    - Worker's compensation;
    - State motor vehicle accident files;
    - State child support agencies.
  - Software that flags potential discrepancies that could lead to a failed match, such as:
    - Incorrect member ID number;
    - Subscriber or dependent name misspelling;
    - Incorrect date of birth.



# Third Party Liability (TPL) Identification

## Considerations

- Processes are generally uniform across a state Medicaid program.
- Likelihood of identifying third party payers and achieving cost avoidance is greater if the state has the tools and data to complete data matching.
- States often contract TPL identification to an external vendor.

## Essential Test Met

- ✓ Individual was eligible for the waiver on the date of service.

# Electronic Visit Verification (EVV)

- **EVV:** A technology-based method of verifying home visits with respect to the:
  - Type of service performed;
  - Individual receiving the service;
  - Date of the service;
  - Location of service delivery;
  - Individual providing the service;
  - Time the service begins and ends.
- Although states are not currently required to use EVV, a number of states have implemented EVV systems as part of their fiscal integrity strategy.
- EVV systems are often linked to approved service plans.
- In some cases, providers can also submit claims through the EVV system.
- Some vendors also allow waiver individuals to validate services were provided.
- For self-direction, some EVV vendors enable individuals to track budget balances.

# Electronic Visit Verification (EVV)

## ➤ Types of EVV

- Phone
- Tablet computer with electronic signature
- Cell phone or mobile GPS with electronic signature
- Biometric recognition (e.g., fingerprint recognition, voice pattern identification, etc.)

## ➤ Different requirements

- States can contract with a single vendor and mandate all providers use that vendor.
- States can allow providers to choose their own EVV system based on minimum technical and functional requirements and timelines established by the state.
- Take into account a stakeholder process that includes individuals, families, advocates, and providers.

# Electronic Visit Verification (EVV)

## Considerations

- Can help ensure individuals receive the services authorized in their service plan by providing real-time tracking.
- Promotes providers having proper documentation, reducing time and administrative expenses associated with responding to an audit.
- Reduces state staff time spent conducting an audit (e.g., requesting and reviewing service documentation).
- Can be expensive to implement and requires testing prior to rolling out to providers.
- Many providers use EVV systems even when it is not required by the state; states must decide whether to allow providers to continue using existing systems.
- Does not address all types of fraud, waste or abuse (e.g., a personal care attendant using EVV may still be unqualified to render services).

# Electronic Visit Verification (EVV)

## Considerations (Continued)

- States must establish standards, policies and procedures, training and technical assistance related to:
  - Functional capacity;
  - Billing integration;
  - Interoperability with other data systems;
  - Data sharing;
  - Alerts when providers are late or miss shifts;
  - Data storage and security;
  - Disaster recovery.

## Essential Tests Met

- ✓ Service was included in the individual's approved service plan.
- ✓ Services were provided.

# Medicaid Management Information System (MMIS) Edits

- **1903(a)(3) of the Act, 42 CFR 433.111:** A Medicaid Management Information System (MMIS) is a “mechanized claims processing and information retrieval system.”
- When a claim is submitted to the state’s MMIS, it is assigned a unique identifier and run through the adjudication process.
- Claims are subjected to federally-required and/or state-specific automated “edits” to check for consistency, format, reasonableness and allowable values. For example:
  - Duplicate payment checks
  - Provider and recipient eligibility checks
  - Coverage checks
  - Various other edit checks that are specific to provider types and specialties.
- Claims that fail an edit check can be automatically denied, or suspended for the state to review before they are adjudicated.

# Medicaid Management Information System (MMIS) Edits

- Some common examples of MMIS edits are:
  - Verify that individuals are eligible for waiver services on the date of service.
  - Check providers were enrolled on the date of service and eligible to receive payments (i.e., without sanctions / exclusions that would prevent payment).
  - Confirm provider is eligible to render service(s) during the claim period.
  - Verify the provider is eligible to render the specific service to the specific individual (e.g., conflict-free case management).
  - Establish pre-programmed service limits, including service limits for mutually exclusive services (e.g., respite and personal care).
  - Determine whether billed amount is consistent with the allowable fee schedule.
  - Validate prior authorization issued for services requiring prior authorization.
    - States will typically only issue prior authorizations for services that are included in the individual's service plan.
  - Validate claim does not exceed prior authorization limits.

# Medicaid Management Information System (MMIS) Edits

- Some common examples of MMIS edits are (continued):
  - Validate service or taxonomy codes on the claim.
  - Check that procedures are consistent with diagnosis(es).
    - Note that service plans should be person-centered and not based entirely on diagnoses.
  - Verify procedures are consistent with age / gender.
  - Flag claims from a single individual for multiple visits on the same day to the same provider.
  - Confirm provider type is consistent with the procedure(s).
  - Check procedure is consistent with place of service / category of service.



# Medicaid Management Information System (MMIS) Edits

## Considerations

- Uses existing system to perform pre-payment validation using automated logic.
- Logic must be well-defined and validated.
- If the state uses a fiscal agent to operate the MMIS, seek their input on edits or billing validation for your program.
- States must consider any exceptions to the edits.

## Essential Tests Met

- ✓ Individual was eligible for the waiver on the date of service.
- ✓ Service was included in the individual's approved service plan.

# Predictive Modeling

- Predictive modeling identifies and uses outliers, anomalies or atypical billing patterns to predict suspicious claims and, more broadly, emerging fraud schemes.
- Predictive modeling strategies:
  - Analyze relevant historical claims, providers and waiver individual data to develop a statistical model or algorithm of future behavior.
  - Make predictions based on the model to recognize the probability of a behavior and determine if behavior is of interest for further review and validation.
  - Adapt and identify new and emerging abnormalities as new information is received.
  - Assess providers based on algorithms that analyze billing, claims and other public and private data to develop a risk score (can also include specialty-based peer analysis).
  - **Linking analytics:** Identify relationships / potential schemes among providers, facilities and members.

# Predictive Modeling

## Considerations

- Predictive models are only effective if they are consistently updated with current data and revisions are made to algorithms based on that data.
- States may gather information about national fraud, waste and abuse trends from other states, associations (e.g., National Association for Medicaid Program Integrity or the National Association of Medicaid Fraud Control Units) and the Office of the Inspector General (OIG) to inform algorithms.
- States should pair predictive models with pre-payment review—states must be able to act based on the information revealed by the model for it to be effective.
- States can use the results from its evaluation of predictive models to:
  - Prioritize staff and budget for risky claims and providers.
  - Take action by reviewing, suspending or terminating providers.

## Essential Test Met

- ✓ Services were provided.

# Pre-Payment Review

- Pre-payment reviews are desk or onsite reviews of claims prior to reimbursing a provider. Pre-payment reviews determine if services were rendered in accordance with state policies and procedures.
- As part of a pre-payment review:
  - Flag high-risk claims and providers for pre-payment review.
  - Review supporting documentation (including approved service plans and/or individual eligibility information) for claims after submission, but prior to payment.
  - If claim is legitimate, approve it and release it back into the system for prompt payment.
  - If reviewers determine the claim should be denied, attach a denial reason code (e.g., the authorization number is missing, invalid, or does not apply to the billed services or provider), which can be used for:
    - Tracking;
    - Reporting;
    - Identifying provider training opportunities.

# Pre-Payment Review

## Considerations

- Pre-payment reviews require manual intervention by the state.
- Ensures supporting documentation exists before money leaves the waiver program.
- States must have a method of prioritizing claims for review.
  - Predictive modeling;
  - Utilization;
  - Previously identified issues.
- States must ensure that pre-payment reviews do not violate timely payment regulations.

## Essential Tests Met

- ✓ Individual was eligible for the waiver on the date of service.
- ✓ Service was included in the individual's approved service plan.
- ✓ Services were provided.

# Integrated Data Systems

- Several states are implementing integrated case management systems to share individual, provider, service, and transaction data.
- Eligibility data
  - Financial Medicaid data;
  - Third-party liability data;
  - Level of care assessment / re-assessment data.
- Enrollment documentation
  - Freedom of choice forms
  - Waiver agreements
- Service plans
  - Goals, objectives, interventions / services;
  - Service providers;
  - Service authorizations (including type, scope, amount, duration and frequency);
  - Natural supports;
  - Back-up plans.

# Integrated Data Systems

- Appeals for denied eligibility or services.
- Case management
  - Documentation of case management activities, including required contacts with the individual.
- Incident reporting
  - Reports of abuse, neglect, exploitation or unexplained death associated with an individual or provider.
- Provider management
  - Registry of approved and qualified providers.
    - Designation of provider status, division, specialties, services, etc.
    - Summary of substantiated allegations and investigations.
    - Sanctions, corrective actions, etc.
- Claims for services provided.

# Integrated Data Systems

## Considerations

- Reduces state staff administrative time
  - Allows staff to manage all aspects of individual care from a single system.
  - If systems are integrated, validation can be conducted electronically.
- Provides many opportunities to crosswalk and validate data. For example:
  - Do claims match up to eligible individuals and providers for services that are authorized in the service plan?
  - What is the effectiveness of sanctions / corrective actions in changing future provider behavior?
- In addition to helping with fiscal oversight, an integrated case management system can be a useful tool for waiver program managers to monitor and report on quality.
- Requires training of waiver staff.



# Integrated Data Systems

## Essential Tests Met

- ✓ Individual was eligible for the waiver on the date of service.
- ✓ Service was included in the individual's approved service plan.
- ✓ Services were provided.

# Summary

- States can use multiple methods for billing validation in addition to post-payment reviews.
- States should consider the relationship between methods they choose to implement. For example:
  - MMIS edits that do not lead to an automatic denial of claims may require a pre-payment review to adjudicate suspended claims.
  - Predictive models can leverage data from integrated case management systems.
  - EVV data can be included as part of an integrated case management system so state staff / case managers can monitor service delivery in real-time.
- States should document these methods in Appendix I-2-d and include a reference to post-payment review processes that may be included in Appendix I-1.

# Summary

## Crosswalk of Billing Validation Strategies and Essential Tests

	Individual was Eligible for the Waiver on the Date of Service	Service was Included in the Individual's Approved Service Plan	Services were Provided
Eligibility Verification	X		
TPL Processes	X		
EVV		X	X
MMIS Edits	X	X	
Predictive Modeling			X
Pre-Payment Review	X	X	X
Integrated Data Systems	X	X	X

# Additional Resources

- <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>

# Questions & Answers

# For Further Information

**For questions contact:**

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**Thank you for  
attending our session!**