**MACOMB COUNTY COMMUNITY MENTAL HEALTH**

**OFFICE OF SUBSTANCE ABUSE (MCOSA)**

**Medicaid Billing Verification Audits Summary**

**October 2020**

MCOSA monitors subcontract providers several times throughout the fiscal year to ensure compliance with the Quality Assurance Guidelines, Data, Financial and Billing completeness and accuracy, and compliance with Contract requirements. The audit tools and the subsequent reports generated by these monitoring activities are on file, by Fiscal Year, at the Office of Substance Abuse. The audit tools are updated, as needed, to reflect changes in contract requirements.

The following includes a summary report for the Annual Contract review and Billing Verification Audit conducted for each subcontracted program.

I. FISCAL YEAR 2020 ANNUAL CONTRACT REVIEW SUMMARY

Each fiscal year, MCOSA monitors the subcontracted Prevention and Treatment Agency’s within the County for compliance with contractual requirements in the following areas:

* Administrative Capacity
* Corporate Compliance
* Recipient Rights & Confidentiality
* FOCUS/Data/Security
* Training & Credentialing
* Financial Management & Reporting
* Quality Assurance
* Prevention Activities

The evaluation process includes a review of policies and procedures, clinical charts, personnel files, direct observation of prevention presentations, and other related documentation. The Annual Contract Review process also incorporates information obtained throughout the year from regularly scheduled Quality Assurance Audits and Financial Review(s).

A summary report outlining the findings from the review, including areas that require a corrective action by the program, is provided to the subcontractor. The subcontractor, in turn, submits a Corrective Action Plan identifying how corrections have been implemented to achieve contractual compliance.

For FY 2020, covering contracting from October 1, 2019 through September 30, 2020, seventeen (17) subcontract providers were reviewed for contract compliance. Of these providers, six (6) provide prevention services and thirteen (13) provide treatment services, with some providers offering more than one service.

All subcontractors who received less than a full compliance score on the Annual Audits were required to submit corrective action plans. MCOSA reviewed and approved corrective action plans submitted by subcontractors. Based on audit results and corrective action plans, all subcontractors have shown to be in full compliance with the FY 2020 Annual Contract requirements.

The following table summarizes the findings of the Annual Contract Review from the seventeen (17) subcontract providers.

**FY 2020 Annual Contract Compliance Review Results**

|  |  |  |  |
| --- | --- | --- | --- |
| **Compliance Review Criteria** | **# Providers in Full Compliance (no corrective action needed)** | **# Providers in Partial Compliance (some areas in need of correction)** | **# Providers Not in Compliance** |
| Administrative Capacity | 10 (59%) | 7 (41%)\* | 0 (0%) |
| Corporate Compliance | 14 (82%) | 3 (18%)\* | 0 (0%) |
| Recipient Rights & Confidentiality | 14 (82%) | 3 (18%) | 0 (0%) |
| FOCUS/Data/Security | 11 (65%) | 6 (35%) | 0 (0%) |
| Training & Credentialing | 8 (47%) | 9 (53%)\* | 0 (0%) |
| Financial Management & Reporting | 13 (76%) | 4 (24%)\* | 0 (0%) |
| Quality Assurance | 9 (53%) | 8 (47%)\* | 0 (0%) |
| Prevention Activities\*\* | 5 (83%) | 1 (17%)\* | 0 (0%) |
| Overall Compliance | 4 (24%) | 13 (76%)\* | 0 (0%) |

\*Subcontractors submitted a plan of correction that appropriately addressed the issue and was approved by MCOSA.

\*\*Six subcontractors provide prevention services.

**FY 2020 Consumer Satisfaction Results**

Consumer Satisfaction is evaluated throughout the year on a quarterly basis per subcontracted program. The following chart illustrates the FY 2020 Consumer Satisfaction results by program. Note, data was not received from all providers.

II. FISCAL YEAR 2020 MEDICAID BILLING VERIFICATION AUDITS SUMMARY

Macomb County Community Mental Health is the designated Prepaid Inpatient Health Plan (PIHP) for Macomb County and manages the Community Grant and Medicaid substance abuse plan through the Substance Abuse Network Services Division, the Macomb County Office of Substance Abuse (MCOSA).

In accordance with Uniform Audit Requirements, 2 CFR 200, MCOSA requires all contracted agencies receiving $750,000 or more in federal funding to have an annual compliance audit and submit a copy of the audit report to MCOSA. Providers falling beneath the $750,000 federal funding threshold must submit a copy of their Annual Financial Audit or Annual Report to MCOSA. Subcontracts that receive less than $100,000 in grant funding may be exempted from this audit requirement. Quality assurance and data & finance staff review provider audits and attend to any findings that are related to MCOSA-funded programs. MCOSA is also included in Macomb County Community Mental Health’s (MCCMH) compliance audit performed by an independent auditor. MCOSA’s records are reviewed for compliance with MDCH PIHP requirements for Medicaid dollars as well as the schedules for substance abuse dollars prepared in accordance with the MDCH Audit Guidelines for Substance Use Coordinating Agencies. This audit is submitted to MDCH with MCOSA staff following up on any findings raised by the independent auditors or the Department.

Additionally, MCOSA monitors subcontract providers each fiscal year to ensure compliance with Financial and Billing completeness and accuracy, and related contract requirements.

To meet this objective, MCOSA completed Medicaid Billing Verification audits of contract provider agencies with which we conducted business during the period of March 1, 2019 through February 29, 2020. Billing Verification audits were also conducted for non-Medicaid covered services.

The audits primarily focused on the following requirements:

• A Fee Agreement is properly completed, signed by the individual served, and retained on file.

• Adequate documentation is on file to support the services claimed.

**Verification of Services Billed Review**

Sampling Methodology

Approximately one to two weeks before a scheduled provider review, the finance coordinator generates the agency’s AP Claims Report for the prior twelve months. The coordinator uses the AP Claims Report to calculate the total number of claims billed and the corresponding amount paid for each funding source (Medicaid, Healthy Michigan, Block Grant, PA2/County funds, Women’s Specialty Services, Medicaid Women’s Specialty Services, Healthy Michigan Women’s Specialty Services, or MiHealth).

The AP Claims Report also lists the individuals served who received services during the previous 12 months, broken down by funding source (Medicaid, Healthy Michigan, Block Grant, PA2/County funds, MIChild, or Drug Court). From this report, the finance coordinator randomly selects approximately 5% of the individuals served for each funding source; with a minimum sample size of four. Care is taken to ensure a single individual served with multiple admissions at one provider location is not counted more than once. The finance coordinator assures the audit sample is large enough to meet the minimum sample size for each funding source; which is 5% of the total claims and 5% of the total amount paid. If the sample size does not meet the 5% threshold, additional charts are randomly selected and added for review.

Audit Methodology

All reviews are scheduled by MCOSA, with at least thirty days’ advance notice. Due to CDC recommendations to prevent the spread of COVID-19, all providers submitted the necessary documentation for the reviews to be completed remotely. MCOSA’s audit staff compare the paid billings detailed on the treatment history for each case against the provider’s records. Any and all discrepancies are recorded on a Billing Verification Audit Form and the results are reviewed with a provider representative.

The audit staff assures a signed Fee Agreement is in the chart, as well as monthly verification of individual served eligibility. MCOSA staff verifies that reasonable efforts were made, by the provider, to identify third party funding sources. For Community Grant cases, the reviewer confirms the individual served has provided verification of income; and, assures the provider is appropriately applying the correct co-pay based upon the individual’s income level. If no co-pay is billed for Community Grant funded services, the reviewer confirms an approved Fee Waiver is on file. Any findings are shared with the quality assurance coordinator for incorporation with any quality assurance audits.

In total, MCOSA reviewed selected clinical records and payment documentation for 32,879 claims, representing 25 providers.

Reporting

A final report was prepared for each provider location audited (Attachment B). Audit results were summarized and analyzed in accordance with the following:

* Total number and dollar value of claims processed during the audit period
* Total number and dollar value of the sample
* Number of claims that were found to be deficient
* Dollar value of claims that were found to be deficient

Audit results were distributed to each provider. Unless appealed and approved, discrepancies resulting in money due to MCOSA are deducted from the provider’s next billing reimbursement.

Any findings on a provider’s annual review are given particular attention on the subsequent annual review. If it does not appear the provider has addressed prior audit findings (or if the findings on an annual review appear to be of a serious nature) MCOSA requires the provider’s submission of a Corrective Action Plan. The provider must document the actions they intend to implement to correct any cited issues. The submitted Corrective Action Plan is either approved or denied by the finance coordinator until a workable solution is achieved.

Appeal Process

The provider may appeal any audit findings before financial adjustments are made by utilizing the Appeal Process. There are three levels to the Appeal Process; Level 1 is submitted to the finance coordinator, Level 2 is submitted to the director and Level 3 is submitted to the appeal committee. The provider must receive a denial on the MCOSA Response Form before appealing at a higher level. Recoveries of all deficient claims are made following the Appeal Process.

Findings

Auditors reviewed each sample claim for specific types of exceptions as defined in Attachments A and B. Auditors also included general observations in their review, such as condition of the charts.

MCOSA identified exceptions in 4.4% of the claim dollars in their sample of $832,342.71. Detailed information is provided below:

|  |  |
| --- | --- |
| **By Population/Sample:** | **Contract Providers**  **Dollar Amount:** |
| Population | $11,096,353.16 |
| Claims Audited | $832,342.71 |
| Sample as a % of Population | 7.5% |
| Total Exceptions | $36,508.31 |
| Errors as a % of Sample | 4.4% |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **By Funding Source:** | **Number of Items** | | | **Dollar Amounts** | | |
| **Sample** | **Exception #** | **Exception %** | **Sample** | **Exception $** | **Exception %** |
| **#** | **$** |
| Block Grant | 7,396 | 491 | 6.6% | $127,615.61 | $5,515.69 | 4.3% |
| Medicaid Healthy MI WSS | 50 | 2 | 4.0% | $7,630.00 | $2,574.00 | 33.7% |
| Medicaid - State Plan WSS | 62 | 1 | 1.6% | $9,586.00 | $783.00 | 7.7% |
| Medicaid - State Plan | 11,876 | 629 | 5.3% | $252,704.63 | $12,346.46 | 4.9% |
| Medicaid Healthy MI | 13,221 | 621 | 4.7% | $408,435.60 | $14,000.00 | 3.4% |
| MIHealth | 130 | 12 | 9.2% | $7,863.87 | $366.16 | 4.7% |
| PA2 | 46 | 44 | 95.7% | $1,158.00 | $968.00 | 83.6% |
| Statewide | 72 | 1 | 1.4% | $12,911.00 | $0.00 | 0.0% |
| WSS | 26 | 0 | 0.0% | $4,438.00 | $0.00 | 0.0% |
| **Totals** | **32,879** | **1,801** | **5.5%** | **$832,342.71** | **$36,508.31** | **4.4%** |

Summary

The providers audited accepted the audit process and findings and understood that the audits contributed toward meeting MCOSA record-keeping requirements. Records generally were available in a timely manner. MCOSA observed that many of the exceptions noted were due to missing progress notes, or proof of services. Most of the progress notes were in paper form, but there is increasing movement toward electronic records via the providers’ own EMR systems.

Our Quality Assurance Coordinator continues to work with our providers to ensure quality clinical documentation. We continue to provide guidance to agency personnel via telephone communication. New service providers receive on-site training from MCOSA staff. MCOSA also offers on-site training to agencies that have had a change in billing staff, as needed. MCOSA’s continued intention is to ensure high quality standards are met in the most cost-effective manner.