House Study Committee on Community Based Intellectual and Developmental Disability Services Final Report

The Honorable Dustin Hightower
Chair
State Representative, District 68

The Honorable Jesse Petrea
State Representative, District 166

The Honorable Buddy Harden
State Representative, District 148

Ms. Tena Blakey
Director
Soto ALG, Inc.

Ms. Tonya Allen
Director
Mineral Springs Center, Inc.

INTRODUCTION

House Resolution 767 (2015 Session) created the House Study Committee on Community Based Intellectual and Developmental Disability (IDD) Services (the "Committee") for the purposes of examining the current oversight and administration of IDD services to ensure that home and community based services in Georgia are meeting the needs of individuals with IDD and their families.

Representative Dustin Hightower served as the Committee's Chairman. Other members were: Representative Buddy Harden, Representative Jesse Petrea, Ms. Tena Blakey (Director, Soto ALG, Inc.), and Ms. Tonya Allen (Director, Mineral Springs Center, Inc.).

The Committee held public hearings at the Coverdell Legislative Office Building in Atlanta, Georgia on two dates: October 19, 2015 and November 12, 2015. During these meetings, the Committee heard testimony from the following individuals:

- Commissioner Frank Berry
  Department of Behavioral Health and Developmental Disabilities
- Catherine Ivy
  Director of Community Services
  Division of Developmental Disabilities
  Department of Behavioral Health and Developmental Disabilities
- Marcey Alter
  Deputy Director, Medicaid
  Department of Community Health
- Brian Dowd
  Program Director, Waivers
  Department of Community Health
- Janice Jenkins, Utilization Compliance Review Manager
  Georgia Medical Care Foundation
- Dr. Gary Miller, Medical Director
  Georgia Medical Care Foundation
- Don Pollard
  Inspector General
  Department of Community Health
- Mike Walker
  President
  Service Providers Association for Developmental Disabilities
  Director of Hope Haven of Northeast Georgia
- Charles Harper
  Vice President
  Georgia Association of Community Care Providers
- Lisa Sassaman
  Executive Director
  Griffin Area Resource Center
- Mary West Barclay
  George Chambers Resource Center

Further, the committee heard testimony from numerous advocates, families and individuals with IDD. The testimony from the above-mentioned individuals led to the identification of the following issues and the formulation of the accompanying recommendations to address the challenges related to the oversight and delivery of IDD services.

BACKGROUND

Historically, individuals with intellectual and developmental disabilities were served in state psychiatric hospitals. In 1842, Georgia opened its first psychiatric hospital, Central State Hospital, in Milledgeville. This hospital became the state's largest facility for the treatment of individuals with mental health issues and developmental disabilities, and quickly grew to be the largest insane asylum in the world. Over the years, four additional psychiatric hospitals were opened throughout Georgia.

Decades later, investigations by the United States Department of Justice (DoJ) into the conditions in these state hospitals revealed that the infrastructure for treating IDD patients in state hospitals was crumbling. Due to inadequate levels of nursing staff, educational staff, and physician coverage, patients' civil rights were being violated and they were not receiving sufficient care. These investigations, coupled with three major laws, changed the manner in which IDD patients were treated. The Americans with Disabilities Act (1990), House Bill 100 (1993) and the Olmstead Decision (1995-1999) created a push by the Federal government to move patients from state psychiatric hospitals to community settings.

In 2005, Georgia signed a settlement agreement with the DoJ called the Civil Rights of Institutional Persons Act (CRIPA). The CRIPA settlement, with the support of the General Assembly and the Governor, infused dollars into the 100-year-old mental health hospital infrastructure to bring these hospitals up to a minimal rate of success. In 2007, Georgia entered into a second settlement agreement with the DoJ to address the standard of care provided to individuals with behavioral and developmental disabilities. The DoJ stated that Georgia was forcing individuals to enter state psychiatric hospitals because comprehensive community services did not exist. This led Department of Behavioral Health and Developmental Disabilities (DBHDD) to create an option for individuals to "waive" their right to be served in an institution and instead receive services in their communities.

FUND SOURCES

The majority of the IDD services available are funded through Medicaid waiver programs; state funded contracts; or family support funding. The Department of Behavioral Health and Developmental Disabilities (DBHDD) oversees the administration of two Medicaid waivers: the New Options Waiver (NOW) and the Comprehensive Supports Waiver (COMP). The NOW waiver program enables individuals with less intense and urgent needs than out-of-home residential treatment or extensive waiver services to live independently in the community. The COMP waiver program is for individuals that need out-of-home residential support and supervision or intensive in-home services to remain in the community. These two waivers provide 23 distinct medical and social services. As of July 30, 2015, there are 7,324 individuals on the COMP waiver and 4,643 individuals on the NOW waiver. Additionally, there are 8,148 individuals currently waiting to receive a waiver. These individuals are either on a Short Term Planning List (STPL) or a Long Term Planning List (LTPL). The STPL encompasses individuals

whose situation or condition indicates the need for services within a short period and the LTPL is for people not imminently in need of services. Some individuals on the LTPL currently receive services through state funded services or family support dollars.

State funded services are similar to the NOW and COMP waiver programs, however, certain medical services such as therapies and nursing are excluded. Family support services are the most flexible fund source and are provided to individuals who live with their families. Families receive up to $3,000 and can utilize these funds for a range of disability-specific services and goods such as respite services or medical supplies.

OVERSIGHT BY STATE AGENCIES

The Department of Community Health (DCH) is the state's Medicaid agency, which means that DCH holds the contract with Centers for Medicare and Medicaid Services (CMS) to reimburse providers for the services administered to patients. DCH delegates the operational responsibility to DBHDD.

DBHDD acts as the operating agency and oversees all enrollment applications of providers. These applications are reviewed by DBHDD to ensure that the services fit the requirements and fit the needs of the population. DBHDD also conducts onsite reviews of all service providers by contracting with Support Coordination Agencies. A provider that receives more than $250,000 in state funds must receive national accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF). If a provider receives less than $250,000, DBHDD will certify the provider through their internal provider compliance unit before they begin operations and these providers will be audited bi-annually. Additionally, DBHDD utilizes an External Quality Review Organization (Delmarva Foundation) to complete onsite reviews of services to ensure that the health and safety of participants meets all requirements.

Testimony suggested that multiple layers of overlapping regulation and auditing have been added largely due to the inability of DCH and/or DBHDD to effectively terminate poor quality providers. Instead, increasing layers of regulations are added to all providers in an attempt to improve compliance or quality of services.

Further, testimony suggested that in order to encourage the quality provider participation necessary to accomplish DBHDD's goals, comprehensive provider pay increases are necessary. DBHDD recently commissioned a rate study based on real costs and supports its implementation. If the State does not provide adequate rates, it cannot recruit and retain high quality providers.

AUDITS

Providers of IDD services must comply with regulations set forth by the Health Care Facility Regulation Division (HFRD), DCH, DBHDD, and CMS. DBHDD contracts with Delmarva Foundation to audit the quality of services provided and DCH contracts with Georgia Medical Care Foundation (Alliant) to audit for program integrity (i.e. to ensure that providers bill DCH for services that they actually provided). When Delmarva and Alliant audit providers, they look for full compliance with all policies and regulations set forth. Some of the policies deal with a participant's care and others deal with technical or clerical issues. Providers must make repayments based on a deficiency, defined as a failure to comply with any policy or procedure

set forth by the Department. A deficiency requires the Department to collect a full recoupment of the amount the Department reimbursed the provider for the service provided.

The current policy surrounding repayments differs from federal law. A memorandum (attached to this report in Appendix A) written in August 2013 from then Inspector General Finlayson to the current DCH Commissioner Clyde Reese states that Federal law defines "overpayment" broadly as funds to which "a person…is not entitled" and mandates that the Medicaid agency (DCH) must seek recovery of an overpayment to the provider. DCH Policies and Procedures have very specific definitions of "overpayment". One of the ten definitions is, "overpayment means a payment to a provider that is… for a service that does not comply with all requirements, terms, and conditions for reimbursement detailed in the Division's Policies and Procedures manuals." The strict definition employed by DCH means that recoupment payments will not fluctuate depending on the severity of the non-compliance. Therefore, providers must make full repayments for clerical errors as they would for a failure to provide a service related to a participant's care. Further, testimony from Mary Barclay, who helped write DBHDD's policy on repayments, suggested that the original intent of the repayment policy was not to penalize providers for clerical errors. Rather, the intent was to prevent fraud and ensure that providers make repayments only for a failure to provide a service.

Additionally, testimony suggested that the auditing process may not be fairly distributed among providers. Providers are selected for an audit based on the following process:

1. Alliant generates a list of eligible provider reviews from the HP claims system and sends the list to DCH for approval by Program Integrity.
2. Program Integrity reviews this list and may remove providers from the list for any reason.
3. Program Integrity returns the revised list to Alliant.
4. Alliant randomly selects providers from the revised list and assigns the provider to a reviewer (Registered Nurses) who then initiates the onsite review process.

The Department stated that their intent is to audit providers who have not had an audit in the past two years, however, the current "random" selection process has resulted in any number (Department staff were not aware of the precise number) of providers who have never been audited. Further, testimony from the Department revealed that some providers may go many years between audits. Meanwhile, other providers are audited routinely.

TRAINING

Currently, there is no formal training for providers on how to stay in compliance with the rules and regulations set forth by DCH and DBHDD. Additionally, each oversight entity creates its own manual on how to stay in full compliance. Although there are overlapping rules among these manuals, they are largely different from one another. Therefore, providers find it hard to stay in compliance because the agencies merely give them constantly changing complex manuals and little guidance. Program manuals change quarterly and this creates a bureaucratic burden on providers and auditors. Further, in order to maintain full compliance with the rules in these manuals, providers must hire individuals whose sole responsibility is to study these manuals and ensure that the provider is meeting all requirements. However, for smaller providers who lack the resources to hire such individuals, the process becomes burdensome.

RECOMMENDATIONS

Based on the challenges addressed in the preceding sections, along with the information gathered from the Committee hearings, the House Study Committee on Community Based Intellectual and Developmental Disability (IDD) Services recommends the following:

1. The Department of Community Health and the Department of Behavioral Health and Developmental Disabilities should evaluate duplicative oversight of providers and remove duplication where possible.
2. The Department of Behavioral Health and Developmental Disabilities should implement service provider rates provided through the NOW/COMP waiver programs as determined by the rate study commissioned by the Department of Behavioral Health and Developmental Disabilities.
3. The Department of Community Health should examine the procedure for auditing IDD service providers to ensure that providers are only required to make repayments for a failure to provide a service or for egregious errors and omissions that affect health and safety.
4. The Department of Community Health and the Department of Behavioral Health and Developmental Disabilities should study and develop a strategic plan to streamline the process by which IDD service providers are audited.
5. The Department of Community Health should examine the procedure for auditing IDD service providers to ensure that all providers are fairly audited. All providers should be audited and there should be transparency in which providers are being audited.
6. The Department of Behavioral Health and Developmental Disabilities should advocate for funding to ameliorate Georgia's current 8,000 IDD individual waiting list for services.
7. The Department of Behavioral Health and Developmental Disabilities should establish a clear and defendable termination policy for dealing with poor quality providers. New providers should have proven depth and experience.
8. The Department of Community Health and the Department of Behavioral Health and Developmental Disabilities should coordinate and provide training on how IDD service providers maintain full compliance with the rules and regulations set forth by their departments and by Centers for Medicare and Medicaid Services (CMS). Interpretive guidelines should be published to insure that providers understand clearly what is expected of them.
9. The Department of Community Health and the Department of Behavioral Health and Disabilities should update program manuals not more than twice per year. Constant quarterly changes in program manuals creates a bureaucratic burden on providers and auditors.

Mr. Speaker, these are the findings and recommendations of your Study Committee on Community Based Intellectual and Developmental Disability Services.

The Honorable Dustin Hightower
Chair
State Representative, District 68

The Honorable Jesse Petrea
State Representative, District 166

The Honorable Buddy Harden
State Representative, District 148

Ms. Tena Blakey

Ms. Tonya Allen

APPENDIX A

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

MEMORANDUM

To: Clyde L. Reese, III
Commissioner

From: Robert Finlayson, III
Inspector General

RE: Identification and Collection of Overpayments

Date: August 15, 2013

Federal law defines "overpayment" broadly as funds to which "a person…is not entitled;" Social Security Act § 1128J(d)(4)(B); and mandates that the Medicaid agency must seek recovery of an overpayment to the provider. 42 C.F.R. § 433.312(a). Whether or not the State recovers from the provider, the federal share of the overpayment must be remitted within one year, except where the provider is bankrupt or out of business. 42 C.F.R. §433.318(b).

On the other hand, DCH Policies and Procedures have very specific definitions of "overpayment." Part I. Definitions (51). Included as one of the ten definitions is, "Overpayment means a payment to a provider that is…for a service that does not comply with all requirements, terms and conditions for reimbursement detailed in the Division's Policies and Procedures manuals." Part I. Definitions (51j).

Since DCH defines an overpayment as a payment for a service that is not in full compliance with DCH Policies and Procedures, I believe that in its reviews and audits, OIG personnel and vendors must include in the identification of an overpayment all such payments for services not in full compliance with Policies and Procedures.

I have therefore directed all OIG personnel and vendors that we have no discretion in whether we should identify a policy violation as an overpayment. Any adjustment of the amount of the DCH determination of an overpayment will occur only:

1. During an administrative review.
2. When an administrative law judge makes a ruling.
3. When the provider pursues full judicial review through the court system.

In each case, there will be a record of the basis for the decision and all parties will be able to determine the rationale for the decision.