PCG Health
Public Focus. Proven Results.™

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Provider Oversight and Investigation for Home and Community Based Services

Case Study

The Client

Ohio Department of Medicaid

The Project

Home and Community Based Services Provider Oversight and Investigations

The Opportunity

The State of Ohio identified an urgent need to separate the role of Medicaid Provider Oversight and Investigation from Case Management to eliminate conflict of interest, increase transparency, and improve overall quality of oversight and investigations. Within weeks of being awarded the role, Public Consulting Group (PCG) was up and running, performing investigations and oversight with unprecedented swiftness and quality.

The PCG Approach

The Ohio Department of Medicaid (ODM), Bureau of Long-Term Care Services & Supports, is responsible for state-level supervision and oversight of ODM-administered Home and Community Based Service waiver programs, and transition to the community projects. PCG oversees providers and manages incidents for the Ohio Home Care and Transitions II Aging Carve-Out waiver programs, the MyCare Ohio Medicare-Medicaid Dual Eligibles program, and the HOME Choice (Helping Ohioans Move, Expanding Choice) "Money Follows the Person" Demonstration Program.

PCG implemented a multi-component approach to provider monitoring and oversight in Ohio that includes

Provider Enrollment and Support

PCG manages enrollment of all Home and Community Based Service (HCBS) Waiver providers. Services include

- Review of provider applications to verify required documentation for both enrolling and re-enrolling providers;
- Checking applicable databases and ensuring automatic checks complete appropriately;
- Educating providers regarding program requirements to improve quality of services provided to consumers; and
- Serving as Customer Call Center fielding all calls project-wide, providing telephonic support to providers by fielding several hundred calls per week.

Onsite Screenings

PCG has helped Ohio satisfy federal and state regulations requiring unannounced onsite screenings for moderate and high-risk provider types by

- Developing a provider screening checklist based on Administrative Code to capture required details during a provider onsite screening to determine provider compliance;
- Developing processes for uncertainties inherent with an unannounced onsite screening;
- Conducting onsite screening using checklist and educating provider in areas of non-compliant findings; and
- Tracking information collected during an onsite screening and producing key analytical reports regarding findings generated from screenings.

Incident Investigation

PCG investigates all incidents for individuals and providers on the Ohio Home Care Waiver, Home Care Carve-Out Waiver, MyCare Ohio, and the HOME Choice program. Each month, PCG investigates more than 1,200 reported incidents under the categories Provider Occurrence, Protection from Harm, and Provider Billing Violations.* PCG completes the following functions:

- Initial verification of an Individual's health and welfare within one business day

- Complete a full investigation in order to substantiate or unsubstantiate incident violations within 45 days
- Approve prevention plans implemented to mitigate risk of incident reoccurrence
- Refer to ODM for additional provider action, overpayment, or fraud
- Refer to other regulatory agencies such as the Ohio Department of Health and the Ohio Nursing Board
- Work with law enforcement, the Attorney General's Office and other investigatory entities
- Produce key analytical reports. Report issues, educational needs of both providers and case managers, and identify trends and patterns.

Structural Reviews

PCG meets face-to-face with identified providers annually/ biannually to review documentation and ensure providers deliver services in a manner that complies with the requirements of Ohio Medicaid. Review process includes

- Prescreening all providers to determine which providers require a review;
- Conducting a face-to-face evaluation of all provider service documentation and billing, scanning all reviewed documentation for record maintenance;
- Reviewing all billing to assure billing occurred as authorized;
- Investigating provider compliance violations;
- Referring to ODM for additional provider action, overpayment, or fraud;
- Referring to other regulatory agencies such as the Ohio Department of Health and the Ohio Nursing Board; producing key analytical reports; reporting issues, educational needs of both providers and case managers, and identifying trends and patterns; and
- Working with the Attorney General's Office to address cases of fraud.

Provider Education

PCG provides home and community based waiver providers with the education necessary to operate in compliance with all rules and regulations. Education includes

- Face-to-face classroom training, webinars, and online trainings; and
- Educational materials and tools based on client direction and analysis of trends and patterns noted in provider questions and citations.

The Result

PCG was awarded the contract and met with the client in late May 2013. While a project of this scope and scale typically requires six to eight months to implement, our client needed services to begin in 30 days. PCG immediately launched an accelerated implementation that included recruiting more than 25 staff members, developing operational plans and protocols, conducting trainings, and procuring a PCG office and equipment. We successfully met the accelerated project start date, now have more than 75 professionals on staff, and continue to deliver high quality services. From data collected through January 2018:

- PCG has processed 17,175 applications.
- PCG has completed 2,217 onsite screenings.
- PCG has completed 77,447 incident investigations.
- PCG has completed 13,810 structural reviews.

Provider Occurrence Issues	Protection from Harm Issues	Provider Billing Issues
• No call/no show • Providing services beyond scope of practice • Regulatory non-compliance • Services delivered without, or not in accordance with physician's orders • Not providing services according to the individualized plan • inadequate communication with team	• Abuse • Neglect (including of self) • Medication errors • Verbal abuse • Theft • Misappropriation • Death • Accident, injury, fall • ER visits • Reoccurrence of an illness or condition within seven days of hospital discharge • Unauthorized use of restraint, seclusion, or restrictive intervention • Unexpected crisis in the individual's home environment • Use of illegal substance • Individual cannot be located	• Fraud • Billing for services not provided; • Billing for more services than authorized • Billing to incorrect codes

*Provider and Individual occurrences managed under the HCBS Provider Oversight and Investigations Project.

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