Long-term Care Financial Reviews

Medicaid programs can lose tens of millions each year through improper claim payments for patients in long-term care (LTC) facilities. The HMS Long-term Care Financial Review solution helps Medicaid Managed Care Organizations (MCOs) identify and recover these LTC overpayments through a structured, thorough analysis.

HMS has more than 40 years of management experience in Medicaid LTC Financial Reviews. We have developed a successful track record of enabling state programs to recover tens of millions of improperly paid claims each year.

How We Work With MCOs and Providers

Each facility selected by the MCO for review is assigned a dedicated auditor, who works offsite to minimize disruption of the facility's daily business office operations. The HMS auditor establishes and maintains a one-on-one working relationship with each provider assigned to them and is available via telephone and email to answer any questions from the provider and to help guide them through the review process.

For each eligible resident in the facility during the review period, HMS performs a comprehensive review of all financial related activity. Financial documents reviewed include the facility census, aged trial balance reports, detailed financial history reports, and any other relevant financial documentation, including, but not limited to, personal need allowance accounts and security deposit accounts.

Potential overpayments are identified through a comparative analysis of the facility's financial records and the MCO's claims payment history and eligibility data.

Recovery types include:

- Patient Liability and Co-Pay
  - Increases in social security, pensions and other income collected by the provider but not reflected on the claim
  - Income offset deduction overpayments
- Identified unapplied patient liability amounts
  - Unreported lump sum income payments made to the facility
- Room and Board, Coinsurance
  - Other payer review
  - Duplicate and overlapping payments
  - Payments made the date of discharge or death and beyond
  - Review of pre-eligibility private payment period for managed Medicaid recipients
  - Disallowed hospital or therapeutic leave bed reservation payments
  - Disallowed coinsurance payments

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Long-term Care Review Process

HMS manages this comprehensive and thorough review process from start to finish, from initial contact with providers to final reporting. As shown below, the process life cycle can last more than seven months to give ample time for the providers to supply documentation and respond to each phase of the review. This process ensures the accuracy of the final results and minimizes provider abrasion.

30 Days

Provider Notification

- Introduction letters sent to providers
- Entrance call held
- Providers have 30 days to submit requested documents

90 Days

Initial Results

- Documentation reviewed, and overpayments identified
- Initial results sent to provider
- Provider has 30 days to review and respond

135 Days

Additional Information

- HMS reviews provider response and sends back additional information reports to providers
- Provider has 14 days to review and respond

180 Days

Final Results

- HMS reviews provider's second responses and issues a preliminary final report
- Exit call conducted
- Review finalized

225 Days

Provider Refund

- Provider submits refund check to lockbox or recoveries are processed via remittance advice
- HMS sends deliverable report to client

To learn how HMS Long-term Care Reviews can help your MCO plans detect improperly paid claims for patients in LTC facilities and identify providers' improper billing and claims practices, contact your HMS representative or hms.com.