

Fraud, Waste and Abuse Management

Ensuring cost-effective, appropriate long-term care.

Long-Term Care is the largest item in most state healthcare budgets. With so many resources at stake, it's vital to have the right safeguards to ensure cost-effective, appropriate care for your program participants and protect program dollars.

To control costs, you need a way to quickly identify the level of care your participants need and their service eligibility – especially when transitioning them between appropriate payers.

With Waste, Fraud and Abuse Management solutions from Xerox, you can be sure the correct payers are responsible for the appropriate costs of your LTC program's participants. The key to transitioning individuals between appropriate payers is to effectively identify your participants' service eligibility. We help you identify the best care settings and the most appropriate payer. And we detect wasteful, fraudulent and abusive practices and billing in your program. Additionally, our automated process controls variance to provide you with independent, objective information while delivering a granular view of participant needs.

In short, we can provide a complete management solution to prevent waste, fraud and abuse in all parts of your LTC program and help conserve scarce resources.

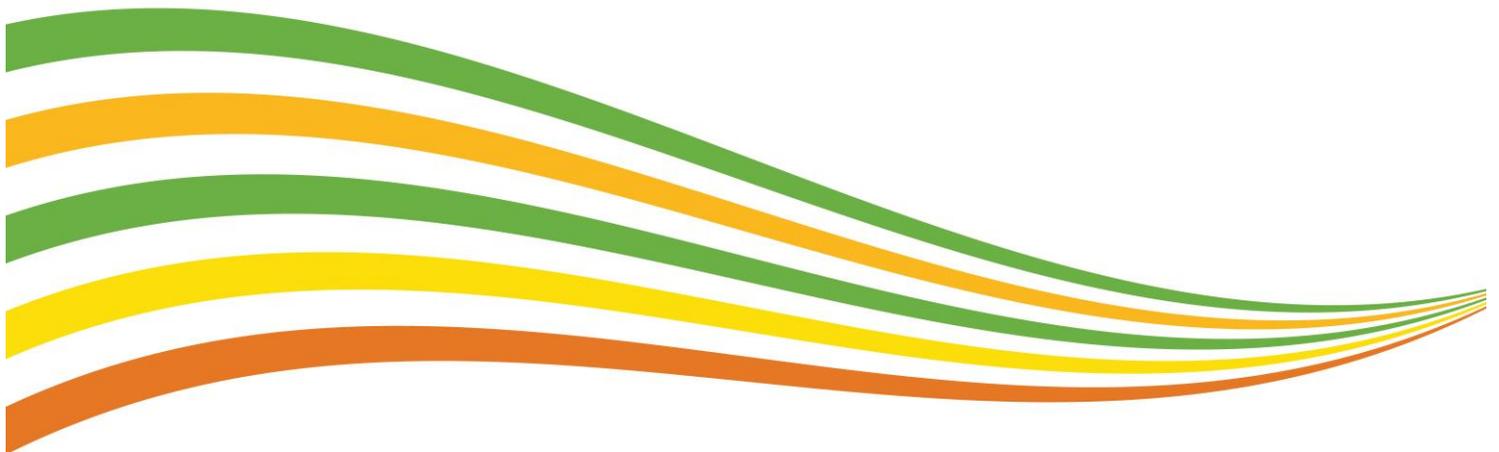
Determine the Appropriate Payer

Your program should pay only for appropriate services – especially where dual-eligible residents are concerned. But when Medicaid pays for services that should have been covered by Medicare, it represents wasted budget dollars that can total thousands.



Solution Benefits

- Increases accuracy of Medicare reimbursement decisions while conserving Medicaid resources.
- Identifies nursing facility residents who are most likely to succeed when discharged and placed in a community setting.
- Captures Medicare funding of home care services for resident's transition to the community.



To prevent this, we use a complex reimbursement review process. We begin by identifying dual-eligible claims made by nursing facilities that have started to move residents from Medicare- to Medicaid-only payments. This prevents Medicaid payments for dual-eligible residents before they occur. Our solution employs a batch process to efficiently analyze a myriad of program criteria, including individual Assessment Reference Dates, Resource Utilization Groups and the associated CMS processes. This helps you clearly identify who covers the treatments individual residents receive and which program is the appropriate payer for them.

If a resident's treatment plan changes, they may no longer qualify for your program's coverage. This increases your risk of paying invalid claims. But our solutions can validate resident coverage before claims are submitted, curbing these unnecessary payments.

We conduct periodic checks to see if residents are still covered. We then dig deeper, reviewing provider-centered operations with medical and financial processes that assign appropriate care to the responsible payer. The provider staff can use the solution to run checks before unnecessarily removing residents from Medicare coverage. We prompt confirmation of current treatments to verify continued coverage, thus keeping the resident on Medicare for the appropriate assignment days. Each evaluation eliminates an unnecessary Medicaid payment before it happens.

Identify the Appropriate Care Setting

Finally, it's important to verify that services covered by your program do not continue longer than necessary and cause you to make extra expenditures. To help, we can also identify institutional residents who should be discharged or considered for community placement. We review and process nursing home Minimum Data Set submissions by screening for residents with functional independence and those needing no care and/or rehab treatment. The solution produces exception reports to determine whether the resident should continue treatment at the facility, if the resident should be discharged or considered for referral to the community with or without home care.

If a resident can be discharged, we focus on transitioning them from a nursing facility to the home or community environment. Our solution identifies residents who may be able to return to the community and receive home care funded by Medicare. If they are found eligible, the State can safely transfer them to the community and ensure that home health services are paid by the appropriate payer.

Long-Term Care for All People in All Settings

The Waste, Fraud and Abuse Management solution is part of our suite of integrated, end-to-end tools and services that help you manage your LTC programs effectively and efficiently and improve outcomes for participants, their families and caregivers whether in the home, the community, assisted living or nursing facilities. By improving access to appropriate services and reducing waste, fraud and abuse, our continuum of solutions integrate with your program to streamline processes, improve access and quality, and reduce cost, helping you provide optimal services in the appropriate setting at the right time.

Most LTC services help maintain or improve an individual's function and independence in a specific setting. But our LTC solutions work across medical and non-medical care environments, acute and chronic illnesses, the aging and individuals with disabilities. By following a person-centered model, we combine the right people, processes and technology to reduce the frustration of families struggling with the many options for service and support.

You can learn more at www.xerox.com/longtermcare. And discover how Xerox creates better outcomes across all parts of the healthcare ecosystem at www.xerox.com/freedomtocare.

Reduce costs. Improve service.

Our Waste, Fraud and Abuse Management solution uses rules-based data analytics fueled by MDS data to determine the appropriateness of funds and payer liability. And our solutions electronically integrate with the MMIS to improve operations, medical and utilization costs while streamlining workflow processes. When you partner with us, you can control your costs and provide better quality service for your residents. Both today and for the long term.

Our Experience

- Decades of experience with Medicaid programs, clinical services, care coordination and payment method reform.
- National provider of HCBS administration support solutions and services.
- Experts in gaining the most FFP and FMAP.
- Proven history of reducing costs and automating administrative processes.
- Continuum of care expertise.