Memorandum

To: Mark Hennessey, Deputy Medicaid Inspector General

From: Home Care Association of New York State
LeadingAge New York
New York State Association of Health Care Providers

Subject: OMIG Proposed Long Term Home Health Care Program Audit Protocol

Date: May 23, 2013

Thank you for inviting our associations to review and comment on the draft "OMIG Audit Protocol – Long Term Home Health Care Program (LTHHCP). We appreciate the previous opportunity to comment on the Certified Home Health Agency (CHHA) protocols and hope that you will give serious consideration to the comments below.

We are grateful for the additional time granted to comment, but the turn around remains a short timeframe to provide feedback, and we note that the comments don't reflect all of our members' concerns and hope we will be afforded the opportunity to provide additional comments at a later time.

Broad-based Comments

We respectfully request that the following broad-based concerns and recommendations be considered and applied to all of the relevant protocols.

1. **Consideration of Situation-specific or other Mitigating Circumstances**
   We appreciate the insertion of language in some of the protocols clarifying OMIG's intentions to consider situation-specific or other mitigating circumstances in cases of compliance findings (i.e. 1, 2 and 4).

   We respectfully request that this intention be reflected either as a prefatory statement applicable to all protocols (with any exclusions so indicated) or that the language be incorporated into those protocols where it is currently missing (e.g., protocol #12, relating to cases where there is no initial assessment in the record or assessment is late, and similarly for other protocols (e.g. 7, 9, 13, 14, 17, 18).

   The May 15, 2013, OMIG Audit Protocols for OPWDD Medicaid Service Coordination provide language that is an example of considering situation-specific circumstances. Regarding protocol 5 (Missing Medicaid Service Coordination Agreement), the language states, "Evidence may include a copy of the Agreement or a monthly service note indicating the Agreement was received."

   In addition, the appropriate protocols (#9, 12 and 13) should indicate that LTHHCPs will not be held responsible for late assessments and reassessments in cases where the local department of

social services (LDSS) is late in fulfilling its responsibilities. This has historically been an issue in New York City and some other counties. Also, there are inconsistencies of practice from the LDSS that the LTHHCP are being held to, which create challenges for LTHHCPs.

2. **Reasonable Allowances for Adherence to Tasks and Time Frames**
We appreciate the inclusion of flexibility reflected in compliance determinations with a number of the protocols. Such allowances/flexibility have been included in some of the protocols, but they are absent from other protocols where similar flexibility is also justified, particularly in the face of total payment recovery upon a finding when reasonableness would dictate otherwise. The 2009 version of the protocols provided for such flexibility for some of these other audit areas.

   For instance, the 2009 protocol #8 stated that a disallowance would be taken if the physician order and/or plan of care was reviewed and signed by the physician more than 90 days prior to the date of service while the 2013 draft (protocol #4) provides only 60 days. This has been a problematic area for home health providers over which they have very little control and previously was discussed at length with the Department of Health and OMIG. In addition, the 2009 protocol #28 allowed an additional 4 months for employees to obtain a PPD skin test (for a total of 16 months) while the 2013 draft protocols (#33) allows only 12 months.

   We recommend broadening the allowance/flexibility provisions to the additional protocol areas.

3. **Proportionality of Disallowance to Compliance Finding**
Emphasized prior to, during and after the OMIG Working Group was the need for proportionality of fiscal sanctions/recoveries to compliance findings, especially when medically necessary services were delivered in good faith by the provider.

   OMIG has recognized in other contexts that a partial claim disallowance is often appropriate and has instructed its auditors accordingly (e.g., see the final "OMIG Audit Protocol – Office of Mental Health (OMH) Rehabilitative Services – Adults"). Yet the majority of the LTHHCP protocols continue to evidence an "all or nothing" approach to sanction, therefore lacking any sense of proportionality or recognition of services that were duly rendered (e.g., #7,12,13; protocol #12 would make a late assessment result in the full denial of payment of claims for medically necessary services that were duly provided and billed).

   We respectfully request that proportionality be reflected as either a prefatory statement applicable to all protocols, or with each protocol for which recovery is at issue.

4. **Non-compliant Personnel Documentation Does Not Justify Total Disallowances**
In addition, the protocols include no parameters or limits on the auditors' authority to disallow claims in full when documents are missing from an aide's or caregiver's personnel file (e.g. #26-35). This is troublesome for several reasons. First, here and elsewhere in the protocols, the requirements for operating a LTHHCP – in this instance, fully compliant personnel records – are essentially being converted into a condition of payment when there is no basis in the cited regulations or otherwise for linking those requirements to payments. Second, the protocols do not instruct the auditors to give the agency an opportunity to search and locate the missing documentation before the disallowance is taken. Third, the auditors could disallow the claim in its

entirety even if the employee with the missing documentation may have provided only a portion of the hours or services for which the LTHHCP was paid.

5. **Documentation Compliance is Being Unfairly Measured by Subjective Review**
   As we emphasized in the January 7 meeting on the CHHA protocols, and relevant to the LTHHCP protocols, compliance with documentation standards is being measured by a subjective review process that is not otherwise circumscribed by the language of the protocol. In the absence of the use of documentation benchmarks, providers will be held to the subjective review of OMIG staff about what constitutes desirable, acceptable or threshold level documentation of the care needed or provided. This approach also compromises the integrity of the overall audit process.

   Given the known variation in clinical practice (documentation included) throughout the health and medical field, it is unfair to apply such documentation review based on unilateral opinion by audit reviewers over a clinician's level or content of documentation. This is particularly concerning given the significant consequences of any resulting payment denial.

   We urge the elimination or substantial revision and circumscription of this audit aspect and in appreciation for Medicaid integrity concerns, urge extensive education sessions for providers on best practices in clinical documentation.

Protocol-Specific Concerns

Some of the issues we have identified with specific protocols include:

#3 – Billed Medicaid Services Before Services Were Authorized –This protocol allows no room for consideration of provider-specific practices, including obtaining and documenting a practitioner's verbal order and subsequent written reconfirmation or other case-specific considerations.

#7 – DMS-1 Not Documented/Late/Incomplete
#9 – Home Assessment Abstract Not Documented/Late/Incomplete

The assessment period for LTHHCPs was changed from 120 days to 180 days effective September 1, 2010, as participants' existing 120 day authorizations expired and subsequent reassessment could then be authorized for 180 days (11 OLTC-ADM -1 Long Term Home Health Care Program Waiver Renewal). These two protocols should be amended to reflect this change.

#7 – DMS-1 Not Documented/Late/Incomplete
#9 – Home Assessment Abstract Not Documented/Late
#12 – Initial Assessment Not Documented/Late
#13 – Comprehensive Assessment Not Documented/Late
#14 – Missing Plan of Care/Order

The "all or nothing" nature of these protocols is problematic. A missing assessment is very different from a late assessment and should be treated differently. Denial of a full claim for a late assessment is unnecessarily harsh and should be changed. Instead, there should be a partial disallowance. Events outside of the provider's control, such as untimely action by the LDSS, could also impact receiving

documentation in a timely matter. In addition, we have recently experienced weather that has had a tremendous impact on the health care delivery system and should be taken into consideration.

The OMIG Audit Protocols for OPWDD Medicaid Service Coordination (protocol #7) provide useful language that should be adapted to the LTHHCP protocols: "If no Individualized Service Plan is in place for a particular time period, there will be disallowances for the dates of service within that time period."

#15 – Failed to Provide Services as Required by the Plan of Care/Medical Orders –This protocol needs to clarify what is meant by "services billed by the LTHHA are not consistent . . ." For example, if services billed are less than those ordered, they should be allowed with an explanation, i.e. patient had a doctor's appointment.

#17 – Supervision Visit Not Performed Within Required Time Frame—This should be revised to indicate that if the required HHA supervision was not documented within the required time period, the paid claim <u>for services provided after the supervision due date</u> (underlined is new language) will be disallowed.

#18 – Supervision Visits Not Performed by PCA Within Required Time Frame –This needs to be revised to include the actual time period, not the general language of "within the required time period. . ." The suggested revision in #17 should also apply to this protocol.

#19 – Failed to Maximize Third Party/Medicare Benefit
#20 – Billed for Services Performed by Another Provider/Entity

These sections need to be revised to recognize that Medicaid is the appropriate payer in cases where Medicare has been billed and is no longer the appropriate payer. Many providers struggle with how to make split-billing work so the patient can remain at home. Often there is a reasonable explanation for utilizing PCA hours instead of HHA hours, and the OMIG should consider documentation from the provider that supports this practice.

#21 – Incorrect Rate Code Billed –This should be changed to reflect that if the paid claim amount is less than the appropriate claim amount, the agency will be reimbursed the difference. The OMIG Audit Protocols for OPWDD Medicaid Service Coordination (protocol #9) provides language that should be used for the LTHHCP protocol #21: "The claim will be adjusted if the incorrect rate code is billed. The disallowance will be the difference between the amount of the incorrect rate code billed and the amount of the correct rate code."

#24 – Spend-downs- Resolving the issues surrounding spend-downs should be examined in greater detail. The providers continue to work with software billing programs to deduct the spend-downs when Medicaid does not automatically deduct it. Providers continue to track spend-downs as best they can.

#25 – Recipient Enrolled in Medicaid Managed Care and the LTHHA –This needs to be clarified to explain what is meant by "If the criteria is not met, the paid claim will be disallowed." There are three options to determine managed care enrollment status and if the provider utilized one of the options the paid claim should not be disallowed if the documentation supports the attempt to determine enrollment

status. This protocol must also take into consideration that there are cases where, through no fault of its own, the LTHHA is not aware that the patient is enrolled in a managed care plan despite checking ePACES on a regular basis and, for such patients the LTHHCA should not be penalized.

Thank you for this opportunity to comment and for your consideration.

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Submitted on behalf of the following associations and their statewide memberships which comprise the continuum of home and community-based care services and represent the vast majority of New York's LTHHCPs.

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