Policy Title: Regulation & Compliance - Regulatory Proposal for pre- and post-COVID-19

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Brief Description

Direct care providers support efforts to fight waste, fraud and abuse in the state's Medicaid program. However, inconsistent rules and policy interpretations used by dueling Medicaid regulatory entities --DQA and OIG-- have made it nearly impossible for providers to navigate the regulatory landscape. Multiple Wisconsin courts have ruled that current state audit and recoupment practices exceed statutory authority and hold Medicaid provider agencies to an unfair 'perfection standard.' Medicaid providers have been directed to pay back months' or years' worth of income due to minor clerical or charting errors that do not affect the Medicaid claim amount or patient care. These punitive and unfair practices are driving dedicated caregivers out of the profession at a time when our provider network is on the brink of collapse due to underfunding and overregulation. The Wisconsin Hospital Association, the Wisconsin Medical Society, the Wisconsin Dental Association, the Wisconsin Pharmacy Society, the Wisconsin Health Care Association, the Wisconsin Personal Services Association and LeadingAge filed a joint amicus brief with the Wisconsin Supreme Court in March 2020 asking them to address this widespread regulatory issue. They wrote in their joint filing: "recouping payments for *covered services* that were *actually provided* does nothing to prevent such fraud. It only deters qualified health care providers from providing services to patients."

There needs to be consistent regulations and policies between DQA and OIG for both residential facilities and community-based agencies. The subgroup will continue to identify specific areas of concern, including:

1. Regulations need to be consistent between regulating entities (DQA and OIG). There have been numerous instances when a DHS Division of Quality Assurance (DQA) surveyor conducted a survey of a Medicaid provider agency and found full compliance with regulations, only to have DHS OIG auditors issue findings (and seek recoupment) that are inconsistent with the DQA review. Multiple courts have also found that DHS is holding agencies to an unfair "perfection standard." Medicaid agencies have been directed to pay back months' or years' worth of income due to minor clerical or charting errors that do not affect the Medicaid claim amount or patient care. Full shifts have been recouped for minor errors in charting. According to a 2020 survey of Wisconsin Personal Services Association members, 50% of respondents have been ordered by OIG to pay back money due to a clerical error even when care was

appropriately provided and documented. And 42% of respondents said that OIG ordered them to pay back money for a regulatory issue that was in direct conflict with advice from DQA. The audit and recoupment process needs to be reformed to limit recovery efforts to cases of true fraud or abuse--not missed checkmarks.

a. Examples of inconsistencies:
    i. OIG used the skilled administrative code for home health care agencies and nursing homes to scrutinize a personal care agency for recoupment. The agency pointed out that they are non-skilled and that
    they would appeal the recoupment and OIG threatened to shut them down if they appealed the case.
    ii. There have been cases where an agency was asked to pay back funds because a worker had bad penmanship or accidentally wrote the wrong day.
    iii. OIG has sought recoupment alleging the supervisory visit forms do not have enough detail--despite DQA having previously reviewed the forms.
    iv. One agency missed the required 60-day RN Supervisory Visit by <u>one</u> day, and was required to pay back <u>all care</u> that took place during the one-year authorization period.
    v. OIG recouped 6 months' worth of claims from a personal care agency because the PCW wrote his initial on the task but used cursive to initial the bottom of the timesheet when he signed his name. OIG claimed that those were two different people. The agency sent OIG an affidavit by the PCW about the initials, but OIG still sought recoupment.

b. DHS OIG recovery efforts should be limited to instances where:
    i. Services were not actually provided, or
    ii. The amount claimed was inaccurate or inappropriate for the service that was provided.

c. OIG should follow DHS (DQA) practices and work with providers to fix documentation or clerical mistakes instead of requiring them to pay back significant sums of money for cares already provided. 76% of WPSA agencies surveyed said that OIG did not provide them with any guidance on how to fix the "errors" for which they were being fined.

d. DHS OIG should work with providers to develop a resolution process that OIG would have to use before initiating a recoupment/recovery.

e. DHS (DQA) and OIG should give providers at least 30 days from the date they receive DHS's tentative audit results to provide additional documentation not provided to DHS during the audit.

f. Currently, DHS OIG can penalize agencies for scheduling RN supervisory visits outside of the normal plan of care hours. Agencies should be given flexibility to work with the client, the personal care worker and the RN supervisor to schedule a time for this administrative visit to occur when it works with everyone's schedule.

g. DHS (DQA) and OIG should not be allowed to pursue or engage in recovery for any claim that is more than 1 year old. Given the high client and personal care worker (employee) turnover rate, an extended look-back period places an unnecessary and excessive burden on providers. Especially, since providers have already paid their caregivers for services rendered. It is not financially sustainable for providers to potentially be asked to pay back money years later. In detail:
    1. *External Audit*: the look-back period should not be more than 90 days for external audits related to client hospitalization.
    2. *Internal Audit:* (OIG onsite at the agency to perform the audit): the look back period should *not* be *more than* 12 months.

2. Ensure Consistent Processes Between MCOs, HMOs. Steps need to be taken to improve communication and coordination in our long-term care system. Personal Care agencies contract with many different MCOs and programs, most of which have their own unique policies and procedures in place. It would reduce administrative burdens on personal care agencies and other providers if all MCOs and HMOs used consistent processes, such as:

a. Consistent billing codes
b. Consistent service authorization processes (i.e., prior authorization period should be at least 1 year, in line with ForwardHealth)
c. Consistent discharge/change of service processes and timeframes when a client is either discharged or has a change in authorized hours. This would help prevent disruption in services.
d. Continuity of care. Clients enrolled in Medicaid often have their insurance plan changed--sometimes without their knowledge. In the event that a client switches health plans, the new plan should be required to honor the old plan's prior authorization/service authorization for 90 days. This will prevent unnecessary disruptions to client care.

3. Electronic Signature Capture. Providers should have the flexibility to use electronic signatures for documentation of services rendered for personal care services. This would simply put providers in this space on equal footing with every other industry in America. Although, providers need the option to decide if electronic signature capture is more feasible or cost-effective for their agency. We are not asking for an industry-wide mandate.
    a. Benefits include faster service delivery - especially for clients leaving acute care settings for their residence. This will allow for a more time-efficient client onboarding process. (i.e., medical records acquisition, service provision consent, increased chance of finding better-matched caregivers).
    b. Electronic signature capture must be HIPPA-compliant.

Analysis

- Anticipated benefits
    - Good Medicaid providers are being driven out of the program due to excessive and inconsistent regulations. Addressing this issue would help encourage provider participation in Medicaid and give consumers more choices of where they receive their care.
    - Reduced operational cost to providers, which leads to available funds to pay caregivers more and to invest in quality care initiatives.
    - These regulatory changes do not reduce care quality to members of our communities, while at the same time ensure reduced waste and abuse of precious Medicaid resources.

- Potential funding options:
  These regulatory changes bear zero cost to DHS/Medicaid.

- What State agency or other entity would be responsible for implementing the proposal, if it were approved?
  DHS (DQA) and OIG

- Cost estimate
  It will save DHS/OIG precious tax-payer resources from unnecessary legal/ administrative burdens.

- Equity issues
  This policy change will benefit all Medicaid providers and consumers. A widespread coalition of groups from the Wisconsin Hospital Association to the Wisconsin Dental Association to direct care providers have called for a solution to these inconsistent and unfair Medicaid regulations and recoupments. It will improve health equity by ensuring that providers are not disincentivized from participating in Medicaid.

- Who will be excluded?
  - No one
- Will anyone disproportionately benefit?
  - Caregivers and members of our communities. Caregivers would realize increased wages/benefits as providers would pass through these cost savings as a result of regulatory efficiencies, and reduced monetary fines.
  - Consumers would receive better quality services and care as the focus would turn to them instead of potential errors that DHS OIG might be recouping on.

- Will anyone be harmed?
  - No one