



Testimony of the

Healthcare Association of New York State (HANYS)

And

Home Care Association of New York State (HCA)

Before the

Senate Committee on Investigations and

Government Operations

Public Hearing on

Medicaid Payment Recoveries and the

Office of the Medicaid Inspector General (OMIG)

January 7, 2010

HANYS and HCA appreciate the opportunity to appear before the Senate Investigations and Government Operations Committee to share their views regarding the Office of Medicaid Inspector General (OMIG) and Medicaid recovery efforts in general.

Introduction

This hearing and its ensuing actions are of immeasurable importance to the health care environment and its future stability in this state. Along with the effects of the cuts to providers in the recent state budget agreements, one of the issues that is clearly generating great concern in the provision of care is the audit approach being taken by OMIG. In this testimony, we explain some of our most serious concerns with regard to the scope and activity of this office, which in its relatively short tenure in this state has created conflict in the health care environment, rather than fostering partnership with government and realistic regulatory expectations focused on the quality of patient care and the true integrity of the payment system.

New York has long been the most heavily regulated health care system in the nation. These regulations exist with their clear advantages and drawbacks. Now, under OMIG, health care providers in New York State face a new interpretation and application of audit standards and recoveries never intended during the formation or enforcement of the majority of these regulations.

We welcome this opportunity to testify today and to hopefully reveal areas regarding OMIG that are in critical need of reform as a matter of fairness, due process, and ultimately the viability of our system.

HANYS and HCA have actively promoted health provider compliance efforts and each has initiated programs and proposals to improve system transparency and integrity. In 2004, for example, HANYS published *Non-Profit Corporate Accountability: A Guidebook*, a “Sarbanes-Oxley for not-for-profits” guide that includes best practices and specific examples of organizational compliance policies such as conflict of interest protocols, corporate codes of ethics, and governance documents. In 2005, HANYS proposed and advocated for the enactment

of mandatory compliance programs applicable to all Medicaid providers. Social Services Law § 363-d is modeled on HANYS' proposal.

Similarly, HCA has also initiated important compliance efforts. Each year, HCA presents a Home Care Compliance Symposium, bringing together the Medicaid Inspector General and compliance experts, including quality and surveillance representatives of the State Department of Health (DOH), experts within HCA's membership and others, to provide invaluable compliance education to a statewide cross-section of home health providers. HCA has worked collaboratively with OMIG to improve the accuracy of home health audit protocols and maintains an ongoing line of communication linking its members and OMIG.

These examples demonstrate the Associations' and our members' commitment to compliance, transparency, and integrity. It is in this spirit that HANYS and HCA wish to share several observations with the Committee.

Medicaid Recoveries

Under federal and state Medicaid laws and rules, "fraud" and "abuse" have very different meanings. Fraud involves an act that is either consciously intentional, or is inadvertent in a circumstance that indicates a reckless disregard of the law. Abuse means an action that is an "unacceptable practice," a regulatory violation, or a simple mistake. When references are made to "fraud and abuse" recoveries, it means everything from conscious, intentional defrauding of the government, to a mistake, to an aberration in practice or standard that might be warranted for the necessary and good faith care of the patient.

HANYS and HCA support efforts to root out fraud because it adds costs to the health care system and diverts resources from patient care. However, it is unfortunate that fraud, billing errors, legitimate compliance questions and other departures from standard practice are combined in the phrase "fraud and abuse," because in the minds of the public it lumps providers who make inadvertent billing mistakes together with truly bad actors.

HANYS and HCA believe that the percentage of fraud and abuse recoveries attributable to “fraud” is a small fraction of total recoveries, and that most recoveries are based on technical regulatory interpretations and new reinterpretations. As the agency charged with enforcement of regulations, OMIG often engrafts new interpretations on existing rules and applies its views retrospectively to recover substantial dollars. All too frequently, these recoveries occur despite the fact that appropriate and satisfactory care has been delivered.

This is not to say that incorrect billing or regulatory departures should be condoned. HANYS and HCA believe, however, that under the current recovery system, the magnitude of recoveries for mistakes can be extreme, which is counterproductive with respect to encouraging self-reporting, and generally disproportionate to the offense. We will discuss this issue in more detail in the Proportionality of Recoveries section.

We believe it is misguided for OMIG to focus its resources on hyper-technical parsing of rules never intended, nor applied, as payment rules instead of real fraud, and that the relative paucity of fraud recoveries bespeaks an agency that is no longer true to its core mission. The Legislature created OMIG to combat fraud. Unfortunately, OMIG has become a recovery-driven agency. HANYS and HCA would welcome OMIG’s refocus on its core mission of investigating and rooting out fraudulent behavior. The Associations believe that recovering dollars through nuanced regulatory interpretation has spawned an inequitable and unfair system that has little or no deterrent effect on fraudulent activity.

The provider community is witnessing the application of rules without regard to the realities of health care delivery. In this atmosphere, providers are held to standards that seriously impair their ability to carry out their core mission, the delivery of health services. The financial and human burden of the audit process is diverting scarce dollars from patient care to massive document production. Increasingly, providers are frustrated and discouraged that the state, through OMIG, is advancing a policy that appears to pursue the goal of money recovery at the expense of quality care.

In the home care system in particular, providers are being held accountable for the actions of others over whom they have no control. Some home care programs, such as the long term home health care program, are designed as a working partnership between local governments and long term programs. Local governments have been forced by their fiscal realities, inadequate staffing or local variations in practice to modify policies and procedures that, while maintaining the partnership, may not adhere to OMIG's strict reading of rules and regulations. The result thus far is that providers who have followed localities' practices are deemed unworthy of compensation: services were not provided "in compliance" with rules. The provider is being penalized for following the directives of agents of the state, yet another arm of the state, OMIG, considers doing so unacceptable. Meanwhile, the patients have been well cared for and the state has benefited from the long term home health care program delivering an alternative to nursing home care at an average of 50% of comparable institutional care costs to taxpayers.

Corporate Compliance Programs

We support and promote internal compliance programs that proactively identify and self-report billing errors—including restitution of excess payments. As previously indicated, the statutory mandate for corporate compliance programs originated in New York's provider community. Corporate compliance is a structure that organizes and guides self-improvement efforts. As one commentator has observed, "Corporate compliance is a journey, not a destination." The measure of an effective program is not the amount of money returned to a payer, but the good faith implementation of processes and procedures that promote compliant behavior.

In this way, a corporate compliance program is similar to a quality improvement program, which is an ongoing process to promote higher quality care. A chief executive officer (CEO) of a provider organization recently commented that when it comes to quality improvement, "It's never enough." The CEO explained that each year, leaders of each department meet with the CEO to discuss the next year's budget. Every patient care unit leader requests funding to improve care quality and patient satisfaction. However, not everyone's request is fully funded—the reality of health care is that there are finite resources to allocate. At the end of the budget

reviews, noted the CEO, one perception is that the CEO doesn't "care enough" about quality improvement: because some funding requests were partly denied.

In October 2009, OMIG began auditing providers' compliance programs to determine their effectiveness, and has stated that these examinations of compliance programs will be part of every audit this year. As such, the Associations are concerned that once OMIG conducts full-fledged audits of compliance programs, nearly every program may fail because it "wasn't enough." Unfortunately, there is no definition of what is "enough."

The Associations' concerns are based on two issues. The first is the intense emphasis on technical rules as a basis of recoveries. The auditing-to-technical-rules phenomenon that has dominated OMIG's efforts thus far leads to the concern that the same methods will be employed when determining compliance program effectiveness. Providers simply lack the resources to conduct self-audits on every detailed regulation. The concern is that OMIG may conclude that the compliance effort, no matter how extensive, will never be enough.

The second is an issue that has lingered for two years. In September 2007, OMIG began a process intended to produce a corporate compliance guidance document to assist hospitals' compliance efforts. The document was to be published in January 2008. Various iterations have been drafted and several providers, compliance officers, and others have expressed substantive concerns to OMIG.

One of the primary issues has been that the document was excessively detailed and substantively unrealistic. Further versions maintain the focus on detail: long lists of laws, rules, regulations, court decisions, opinions, and statements that compliance program activities should encompass.

With regard to the compliance officer, OMIG's recommendation thus far is that the person should have medical, legal, accounting, compliance, quality improvement, governance, and other related expertise. However, OMIG acknowledges that such a person may be difficult to find. Again, what is "enough"?

Unfortunately, the latest version of OMIG's guidance document lacks the one ingredient providers have sought: guidance. The Associations are hopeful that further revisions will occur before the document is completed.

The Current Recovery System

HANYS and HCA wish to bring to your attention several issues that merit your examination:

- the proportionality of recoveries;
- the use of "conditions of participation" as "conditions of payment";
- reliance on guidance from regulatory agencies; and
- auditor expertise, qualifications, and conflicts of interest.

Proportionality of Recoveries

Social Services Law § 363 defines medical assistance as payment for all or part of the cost of medically necessary services or supplies to eligible individuals. Members of both Associations have reported that recoveries are often taken despite there being no issue with the necessity of the care that was provided. The basis for such recoveries is that a billing, coding, or technical rule was not flawlessly met or that a defect such as a misspelled name appears in a record. It appears that these technical matters are where many of the mistakes or technical departure "abuse" recoveries are found.

In addition to seeking recoveries on these grounds, OMIG's practice has been to recover an entire payment for "noncompliance" with a technical rule. In these circumstances, the entire payment is recouped even though medically necessary care was, in fact, provided. The practical effect of the practice is that a technical flaw renders the service apparently worthless, even when the validity of the service is undisputed.

It appears that this practice of recovering 100% of a payment regardless of the "severity" of the infraction has no roots in federal or state statute or regulation. Apparently, it is the result of

recovery agency policy. HANYS and HCA respectfully submit that this practice subverts the intent and clear words of the law: that medical assistance is payment for medically necessary care to an eligible recipient. Under the current recovery agency practice, no “medical assistance” occurs when a billing mistake is made or a technical aberration in practice occurs—in essence elevating technicalities over the legitimacy of service.

In fact, evolving law and health policy support a less punitive approach. The Prompt Pay Law, Insurance Law Section 3224-a, which governs payment practices by health insurers, allows a payer to deny payment or seek more information for only that portion of a provider’s claim that is disputed—the undisputed portion must be immediately paid. That is, something that is arguably amiss in a claim or which can be challenged by a payer does not taint the balance of services that were rendered.

Indeed, the payers themselves have sought relief from the zero tolerance standard for payment delays and, as a result, Insurance Section 3224-a, subsection (c) was amended this year to provide that where a payer has processed 98% of claims in compliance with the Prompt Pay Law, the payer is exempt from civil penalties arising from the Superintendent’s own investigation. Simply put, mistakes happen. We support a similar standard of substantial compliance to forbid payers from imposing technical or administrative denials when medically necessary care has been provided, but some rare inadvertent error has occurred.

HANYS and HCA strongly urge the Committee to look further into the proportionality issue. The Associations believe that a fair and equitable approach can be achieved and we would appreciate the opportunity to explore this further with the Committee. At the same time, we also urge the Committee to consider the legitimacy of OMIG recoveries on technical regulatory grounds or practice departures, when satisfactory services have been delivered and when such rules and practices were never written to be enforced in this fashion.

“Conditions of Participation” as “Conditions of Payment”

State laws and rules include provisions that determine whether an entity may be licensed to provide certain care. To operate a hospital, for example, the provisions of and rules adopted pursuant to Public Health Law (PHL) Article 28 determine if a license should be issued and under what circumstances a license may be revoked. Home health agencies operate pursuant to PHL Article 36, and so on. Similar federal laws and rules spell out the qualifications for being a provider in the Medicare program. These rules are commonly referred to as “conditions of participation.”

Conditions of participation may include general provisions such as that the governing body is ultimately responsible for the quality of care rendered by the provider, or may be quite specific: a hospital may only have a person on “observation” status for up to eight hours and the person must be an emergency room patient; or a plan of care shall be developed for a home health care patient within ten days of admission to the agency.

These provisions, particularly the state licensure rules, do not apply only to certain types of patients, e.g., only insured patients, or only Medicaid patients. They apply to the provider regardless of what program is paying for a specific patient’s care. The rules do not speak to billing, coding or claim submission except in the most general terms and do not contain Medicaid-specific provisions.

These rules have been enforced by regulatory agencies such as DOH, Office of Mental Health (OMH), and others. The regulatory agencies and their federal counterparts regularly survey providers to determine if they comply with their respective conditions of participation. The provider is notified if deficiencies are discovered. An opportunity to correct the deficiency is provided and if the correction is satisfactory, the agency continues monitoring the provider to be assured that recurrences are not happening.

The expertise to conduct operational surveys and determine if conditions of participation are satisfied is vested in the regulatory oversight agency—DOH or OMH at the state level or the Centers for Medicare and Medicaid Services at the federal level.

Home health agencies and hospitals are now seeing these rules applied by OMIG as conditions of payment. In other words, if an OMIG audit concludes that there was not full compliance with applicable conditions of participation, payment for claims generated during the period of non-compliance may be denied. Thus far, OMIG has selectively applied certain conditions of participation to the exclusion of others. It is the Associations' understanding that OMIG's policy position is that payment recoveries may be based solely on OMIG's determination that any condition of participation was not followed.

This development raises obvious concerns. The first is the belief that conditions of participation are payment system rules subject to interpretation by payment system recovery agencies rather than surveillance system enforcement personnel. Similarly, the policy imposes a payment system remedy, recouping payments for services for an operational issue instead of requiring corrective action plans, as are required in the surveillance system.

Conditions of participation were not developed as, nor designed to be, criteria for determining the propriety of specific claims for services. Health care providers are witnessing the misapplication of these rules as if they are Medicaid payment rules. HANYS and HCA ask that the Committee take action to clarify that the respective regulatory agencies are responsible for applying, interpreting, and enforcing these rules—not payment recovery agencies.

Reliance on Guidance

The health care system is beset with countless rules and regulations that are not always clear and are sometimes contradictory. As a result, providers have consulted with regulatory officials to obtain guidance or clarification. Recently, however, providers are facing situations where they have relied on guidance issued by a regulatory agency only to have a different interpretation developed and applied retroactively by the OMIG. Members of the Associations have been

subject to OMIG interpretations and positions that do not comport with prior documents issued by DOH. Further, newly-reinterpreted regulations are being applied in ways never intended by regulatory agencies.

In some instances, the new interpretation is manifested in audit criteria. For example, the criteria apparently applied by OMIG in its audits of hospital clinics in 2008 contradicted longstanding DOH instructions and the applicable regulatory provisions. In another situation, OMIG applied new criteria to recover millions of dollars from nursing homes. An administrative law judge recently ruled that OMIG's methods were improper. OMIG's 2010 Workplan includes an audit initiative to re-open nursing home rate appeals previously approved by DOH. In doing so, OMIG has demanded source documents from as far back as the early 1980s and has taken the position that absent such documents, all payments attributable to the DOH-approved rate appeal are null and void.

As a result of these and other actions, providers cannot follow the guidance or decisions of DOH with the assurance that OMIG will honor DOH's holdings. In this era of transparency and accountability, it is incongruous that positions and interpretations may be changed years after the fact and applied retroactively to recover dollars.

Earlier this decade, similar events occurred at the federal level. Congress responded by including provisions in the Medicare Modernization Act of 2004 that stipulate that if a provider receives written guidance from an agency and the guidance is later deemed incorrect, the provider is held harmless for following the guidance. Prospective compliance with the new interpretation is required, but retroactive application of new interpretations as a basis for recoveries is prohibited.

While the expectation may be that a citizen should be able to rely on the statements and actions of its government, it took congressional action to codify the policy in federal law. HANYS and HCA believe that it is only fair that providers have the same assurance at the state level.

Auditor Expertise and Conflicts of Interest

It has come to the attention of the Associations that in several instances, auditors are simply unfamiliar with the subject area under audit. Providers have been asked to point out regulatory provisions and explain their application. Regulatory citations are misapplied to circumstances not covered by the rule as are misunderstandings of the content of a rule. Repetitive requests for the same information are commonplace. Even more concerning are reports of claim audits being conducted at facilities at which auditors were previously employed or associated.

One result is that an OMIG audit, while burdensome in its own right, becomes more so due to interpretive and administrative lapses. To overcome these hurdles, providers have diverted staff from patient care activities and in many instances have incurred hundreds of thousands of dollars in external expenses, such as legal fees, and internal expenses, such as overtime compensation, renting extra photocopying machines, and the like.

The Associations ask that the Committee seek assurances that OMIG's internal compliance program is addressing these concerns. At the very least, the practice of assigning an auditor to a former employer should be prohibited as a matter of OMIG policy.

Conclusion

The members of HANYS and HCA are diligent, earnest providers struggling with unprecedented financial pressures and an unrelenting regulatory environment.

OMIG was established to rid the Medicaid system of unscrupulous providers and to deny such entities the fruits of their malfeasance. OMIG can fulfill its mission and obtain undiminished recoveries, by pursuing its fundamental mission. The recovery efforts largely used thus far have unfortunately created inequitable results at the expense of hundreds of indispensable providers. We ask that the Committee impose the Legislature's original vision when OMIG was established and eliminate the inequities that have flourished.

The Associations appreciate the opportunity to address the Committee and would be pleased to respond to any questions.