ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

October 1, 2019

Mr. Doug Jones
4501 Business Park Blvd., Ste. 24, Building L
Anchorage, AK 99503

Re: 72 Hour Documentation Requirement & Provider Self-Audits

Dear Mr. Jones,

The Alaska State Hospital and Nursing Home Association (ASHNHA) writes this letter to express concern about DHSS' proposed regulations regarding provider self-audits. ASHNHA is a membership organization representing Alaska's hospitals, skilled nursing facilities, and other health care providers.

Overall ASHNHA supports the proposed changes to AAC 105.230, Requirements for Provider Records. In particular, the following changes have eased some of the burden on providers:

1. Allowing 14 days for record completion for all providers covered by 105.230 as opposed to the current provision of 72 hours, unless professional licensing standards defines the timeframe. One standard for all is a major improvement and will simplify providers' ongoing efforts to monitor their own record completion as well as simplify the process of self-auditing under AAS 160.115. Entities that employ multiple types of professionals that fall under 105.230 would have been burdened by complexity in managing oversight and auditing of timely record completion.

2. Eliminating the requirement to document start and stop times for Evaluation and Management codes. Most importantly, this change now has Alaska Medicaid in alignment with the Medicare coding guidelines' requirement for documenting start and stop times. This will result in less administrative burden on facilities to establish systems to capture and confirm that times are being documented.

However, we do have several significant concerns regarding 7 AAC 160.115 Duty of the provider to identify and repay self-identified overpayments:

1. We realize 160.115 applies to a wide range of service types, making it difficult for the state to define the criteria for which any given claim is audited against. However, it would be helpful if the rule established some boundaries on the number of criteria applied to any given claim. When you consider the potential criteria that could be used for an inpatient encounter, it becomes overwhelming. An example for setting boundaries could be requiring that providers must audit against no less than two and no greater than five criteria. This will reduce the likelihood of wide disparity in the level of auditing done by any given provider. Providers who choose to apply all possible criteria against their claims will have greater findings and potentially greater paybacks than provides who choose to audit on fewer criteria.

2. The statement that providers shall audit once every two years unless the provider is being audited under AS.47.05 is not very clear. Our understanding of the intent is to eliminate the

potential for a record to be audited both under AS.47.05 as well as self-audited. Without advance knowledge of when the state audits will occur, it will be difficult to plan for and conduct self-audits in a time and resource efficient manner. A large organization's sample size will be of a significant size and complexity, requiring considerable resources to complete. For example, an organization with 50,000 annual Medicaid encounters will have a sample size in the range of 300 – 400 based on RATSTATS. If the large organization is able to break the self-audit down over a longer period of time to complete, there is less likelihood for the need to pay for an outside resource to conduct the audit. For example, knowing the first audit is due June 2020, we can begin auditing calendar year 2018 now, starting with Q1, Q2, and Q3, which are now beyond the one year filing period. By starting the audit at its earliest possible time after the one year filing period and spreading the work over several months' time, the facility can potentially use existing staff resources to audit. We cannot see any way to coordinate this work around potential audits under AS.47.05.

However, if the state audits (AS.47.05) always come later than the self-audits, it would make sense for the state to exclude any audit period that was under a self-audit for a particular facility. This would align with the following statement in AS.47.05: "In identifying providers who are subject to an audit under this section, the department shall attempt to minimize concurrent state or federal audits."

3. We are very concerned with the administrative burden the self-audit requirement will create for larger organizations that are already dedicating a great deal of resources to be in compliance with CMS rules. In particular, the Federal requirements to have an effective Compliance Program, which include ongoing auditing and monitoring with a requirement to repay all identified overpayments from Federal health care programs (including Medicaid) within 60 days.

    a. As mandated by section 6401 of the Patient Protection and Affordable Care Act, all health care provider organizations who bill services to Medicare, Medicaid, or CHIP in Alaska are obligated to have a compliance program as a requirement of enrollment.
    b. Chapter 8 of the Federal Sentencing Guidelines specify that at a minimum there are seven fundamental elements of an effective compliance program, including conducting internal auditing and monitoring.
    c. Section 1128J(d) of the Social Security Act requires health care providers who identify an overpayment, to return the overpayment within 60 days.

4. Compliance Program Guidance has been in place since 2000 for Long Term Care facilities. In recent years CMS has been working to reduce regulatory burden with their Patients over Paperwork initiative. While these proposed changes allows LTC facilities flexibility to streamline their ethics and compliance programs, the requirement for auditing and monitoring to prevent and detect improper billing remains. https://www.federalregister.gov/d/2019-14946/p-110

5. In addition to the larger organizations who will already have robust compliance programs in place, the Office of Inspector General of the U.S. DHHS has issued voluntary compliance program guidance for many segments of the health care industry:
    a. Compliance Program Guidance for Ambulance Suppliers (68 Fed. Reg. 14245 March 24, 2003)

b. Compliance Program Guidance for Individual and Small Group Physician Practices (65 Fed. Reg. 59434; October 5, 2000)
c. Compliance Program Guidance for Hospices (64 Fed. Reg. 54031; October 5, 1999)
d. Compliance Program Guidance for Durable Medical Equipment, Prosthetics, Orthotics, and Supply Industry (64 Fed. Reg. 36368; July 6, 1999)
e. Compliance Program Guidance for Clinical Laboratories https://oig.hhs.gov/authorities/docs/cpglab.pdf
f. Compliance Program Guidance for Home Health Agencies https://oig.hhs.gov/authorities/docs/cpghome.pdf

The Medicaid self-audit requirement is duplicative and will only add to the cost of health care in Alaska. We ask you to consider allowing organizations that fall under the Federal requirements for a compliance program to submit evidence of an effective compliance program, in lieu of a separate audit for Medicaid. Specifically, by submitting samples of audit findings that demonstrate accountability for auditing services billed to Federal payers for accuracy.

Thank you for considering these issues.

Sincerely,

Becky Hultberg
President/CEO