Comments for Chapter: 800 Program Integrity

Effective Date: August 1, 2023

Number	Date Received	Comment	Status Result
1	2/17/2023	BMS should expressly state that it will utilize an Administrative Law Judge (ALJ) for the evidentiary hearing and adopt the WV Administrative Procedure Act (W.Va. Code § 29A-1-1 et seq.) for guiding the evidentiary hearing.	BMS will continue its historic practice of utilizing Hearing Examiners to facilitate Evidentiary Hearings to provide a recommendation to the Commissioner of BMS. BMS agreed that the WV APA will be used to govern the evidentiary hearing process.
2	2/17/2023	BMS should consider allowing skipping of levels with the consent and agreement of both BMS and the provider. Several of the disputes may be legal in nature, and requiring protracted steps and proceedings to get to where BOTH parties agree should decide the	BMS believes the proposed process supports providers ability to seek appeals based on legal disputes provided relevant citations are submitted as part of the appeal request.
3	2/17/2023	"A first level appeal without supporting documentation or beyond 30 days of the date of the OPI initial review findings will not be considered"	BMS will maintain the 30-day standard. BMS will update 800.11 to note the following: “Extension requests will be considered when submitted no fewer than 5 business days prior the due date.”
4	2/17/2023	BMS should remove the bolded language or clarify the rejection of this level for lack of “supportive documentation”. While I understand the intent behind this sentence, depending on the nature or reason for the appeal, there may be no “supportive” documentation. Indeed, it could simply be the claim itself that BMS made an error on in review. The bullet-point under the heading appropriately states the need for information where applicable.	BMS will expand the definitions section of this chapter to define "supportive documentation" as "service documentation or citations to relevant authorities considered by the provider to be supportive of the appropriateness of the payments deemed by BMS to be overpaid.”
5	2/17/2023	What are the finalized findings from OPI? Is this the letter from BMS that indicates the total amount to be disallowed which is based on KEPRO's final disallowance report? Essentially, when does the clock start ticking? Is it when we receive the letter from BMS?	Overpayments are considered identified and audit findings are considered final upon the letter date of the final findings letter. Results are considered to be in draft until 30 days after the date of the draft findings letter or upon completion of any request for reconsideration that was granted. Change granted: section 800.11.1 will be changed such that the opening paragraph reads: "Providers may submit a request for reconsideration in

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			response to the initial findings issued by OPI or its audit vendor. Findings are not considered final until 30 days after the date of the draft findings letter or upon completion of any request for reconsideration that was granted"
6	2/17/2023	Clarification needed -- providers are not required to submit recoupment money while in Step 1, the Request for Reconsideration. Providers will have to pay the amount indicated after the Reconsideration has been completed and a new final letter has been issued & the provider enters into Step 2 if they disagree with the findings?	Overpayments are considered identified and audit findings are considered final upon the letter date of the final findings letter. Results are considered to be in draft until 30 days after the date of the draft findings letter or upon completion of any request for reconsideration that was granted. Change granted: section 800.11.1 will be changed such that the opening paragraph reads: "Providers may submit a request for reconsideration in response to the initial findings issued by OPI or its audit vendor. Findings are not considered final until 30 days after the date of the draft findings letter or upon completion of any request for reconsideration that was granted"
7	2/17/2023	Who is the auditing vendor? Is that KEPRO and based on the narrative in the top paragraph, would that mean that KEPRO's final disallowance report starts the clock?	BMS contracts with several auditing vendors, any of which may be asked by the BMS to review any Medicaid payments. A vendor responsible for a particular audit will always be identified in the finding's letters issued to the provider. Overpayment identified directly by the BMS Office of Program Integrity will not identify a vendor.
8	2/17/2023	BMS should clarify/amend the sentence relating to "bear the necessary and attendant costs of the hearing….". This would be counter to due process where each party is responsible for their own costs. While the full hearing costs by the provider may be appropriate if the provider loses, the full costs should not be borne by the provider if they prevail and BMS loses.	Prior to findings becoming final providers will be afforded an opportunity to request reconsideration of any findings they disagree with at no cost. BMS will maintain its historic practice with regard to the cost associated with any appeals requested subsequent to the request for reconsideration.
9	2/17/2023	Provide with specificity the databases to be reviewed. The inclusion of broad phrase "publicly available	BMS is required to take adverse action when particular sanctionable activities are reported to the BMS through

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		databases" without limitation creates significant ambiguity in the requirement. Without specificity, a provider may be unaware of a certain "public database" and therefore unknowingly violate this section.	public as well as non-public databases (such as the CMS DEX system, which state Medicaid agencies are required to monitor and take adverse enrollment actions, such as termination or exclusion, based on the activity reported there). BMS asks that providers review all publicly avaliable databases monthly as a means of preventing ineligible providers from rendering services to the greatest extent possible and so that they may avoid billing for services for which payment would not be allowable and, as a result, subject to recovery upon a determination by the BMS that the provider was ineligible to render the billed service at the date of service reported. Section 1.1.2, subsection (c) of the Medicaid Provider Enrollment Compendium, which is issued by CMS, states: "A Medicaid overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act. After Medicaid identifies an overpayment, the overpayment amount becomes a debt the provider owes the State Medicaid Agency."
10	2/17/2023	Remove the "monthly" requirement and restore the original language. Alternatively, cross-reference the CARES background check section in lieu of specifying a set time period. To the extent a timeframe is necessitated, then BMS should consider utilizing "annual" as a replacement for "monthly."	Reducing the frequency at which providers review the eligibility of their affiliated providers would likely increase potential for and duration at which ineligible providers could be rendering services inappropriately. Further, recoveries of overpayments for services rendered by ineligible providers would likely be much larger under the suggested change. For these reasons, no change will be made.
11	2/17/2023	Strike the sentence (2nd to last sentence in last paragraph) suggesting an automatic loss of monies for	BMS is required to recovery overpayments made to ineligible providers based upon Section 1.1.2,

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		services provided by an ineligible individual. While this sentence may simply be inartfuly written, the proposed language suggests automatic recovery of monies for all services. This could lead to an unfair/unrelated penalty on the provider for services provided by an ineligible provider unrelated to the direct care of a resident. Additionally, how would the recovered services be calculated. For instance, if a janitor is unknowingly deemed ineligible because of a subsequent arrest that the provider doesn't know about, then is the provider to be penalized for services provided by that ineligible person for every room that person cleaned? To resolve this potential confusion, the sentence should be removed. Appropriate penalties exist elsewhere in the Manual or Rules for Participation making this sentence unnecessary. Alternatively, you may consider revising t this sentence/penalty to be permissive language.	subsection (c) of the Medicaid Provider Enrollment Compendium, which is issued by CMS, which states: "A Medicaid overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act. After Medicaid identifies an overpayment, the overpayment amount becomes a debt the provider owes the State Medicaid Agency." In the example provided, the provider would only be subject to recovery if the referenced ineligible janitor is identified as the servicing provider on claims submitted for reimbursement.
12	2/17/2023	BMS should amend the use of extrapolation to authorize only with the consent of the Provider. While extrapolation may be a CMS-recognized method to determine disallowances, there is potential for misuse or incorrect computations. For instance, the contractor reviews 10 files and finds issue with three of the ten (30%). This would mean that BMS could extrapolate 30% of all claims paid, when the reality is that those are the only 3 errors out of 1,000 claims. However, given the complexity of reviewing all files/claims, I recognize extrapolation may be a preferable method for both BMS contractor and the provider. Accordingly, the use of extrapolation (versus actual) should only occur with the consent of the provider.	As the Single State Medicaid agency BMS retains the authority to utilize extrapolation when it deems necessary. Requiring provider approval would impair the ability of BMS to effectively safeguard state resources. Extrapolation is a widely accepted audit practice and serves to reduce the overall burden associated with audits as fewer records will be needed for review. Audit subjects may request reconsideration or appeals of extrapolated findings which providers believe deviate from sound audit practices.
13	2/17/2023	Charging interest during the appeals process is an incentive to avoid appeals and limit due process	References to interest have been removed from this chapter.

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14	2/17/2023	If the appeal process reverses either all or part of the disallowance, will providers also be reimbursed for any interest that was charged throughout the appeal process? Also, what will the interest rate be?	References to interest have been removed from this chapter.
15	2/17/2023	BMS should not accrue interest on appealed disallowances, especially when the new appeal process could extend for quite some time. As drafted, BMS would financially benefit through increased interest by delaying/dragging out the appeal process. By imposing interest on monies through a payment plan or in which a lien is placed in lieu of payment, BMS could financially benefit by continuing the evidentiary hearings and/or having the Office of Legal Services setting on a matter for an extended period of time outside of the 60 days as allowed under the DDR. Instead, the converse should be utilized to financial incentivize BMS to move the appeal quickly if interest was not accruing.	References to interest have been removed from this chapter.
16	2/17/2023	The proposed changes include new language incorporating a requirement that the CMS Medicaid National Correct Coding Initiative (NCCI) be implemented. While I am unaware of the particulars of the NCCI coding system, care should be taken to ensure duplicative coding requirements are not placed upon providers than those currently being utilized. Specifically, long-term care providers currently utilize certain CMS MDS coding. To the extent the NCCI initiative would necessitate a different or separate coding requirements for a provider, then this proposed language/requirement should be revised to grandfather in existing CMS-approved provider coding uses for particular industries. However, if they are not in conflict, then I have no comment as to this provision.	The BMS implementation of NCCI will continue to leverage the CMS granted waiver for particular sets of NCCI edits. If this waiver were to be revoked or modified by CMS in any way BMS would provide notice to providers prior to implementation. Given NCCI is a nationally standardized sets of edits issued by CMS, we do not believe their implementation presents a risk of duplicative coding requirements.

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17	2/17/2023	BMS should consider removing this section/paragraph in its entirety. Alternatively, it should consider keeping only the first and last sentences. This appears to be a new section added as part of the proposed changes. The proposed language utilizes an undefined term of “operational deficiencies” which could be susceptible to ambiguity and/or contradictory interpretation. There are a number of items that a provider could receive during a recertification that could be deemed a “deficiency” that should never arise to the level of warranting disenrollment (i.e. not changing the coffee pot filter). This broad language should not be used and/or allowed for potential misinterpretation. Finally, the Rules for Participation and BMS Policy Manual spell out the changes.	BMS will expand the definition section of this chapter to include the following definition for "operational deficiency": "Deficiencies identified by or reported to the BMS which constitute a breach of the WV Medicaid Provider Manual or State or Federal law."
18	2/17/2023	The proposed changes include a new allowance for Pre-Payment Review of claims. While such reviews may be appropriate under certain circumstances, they should be exceptions and only utilized when warranted for good cause or where there is demonstrable misconduct by a provider. As referenced in the proposed language, delayed payment due to prepayment review severely impedes the financial flow and needs of a provider. In light of such, BMS should consider adding qualifying language to the proposed language.	BMS will adopt this change.
19	2/17/2023	BMS should consider adding a fourth option for placement of disallowed monies into an escrow account during pendency of an appeal. As it is currently written, the provider is required to first return monies on a disputed disallowance. This seems counterintuitive for an appeal. While a provider may still choose to utilize one of the 3 options listed, they are not really applicable to a challenged/disputed disallowance. Rather, the 3	As the Single State Medicaid Agency BMS is authorized to recover and retain funds found to be overpaid through audits of billed services.

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		options have the effect of being presumed guilty, then proving innocence. This especially becomes problematic for a provider who must first pay to CMS and then engage in a costly appeal process that they may ultimately prove vindicated. The provider then has to deal with a further protracted delay to try and get the monies back from CMS. It seems there should be allowance for a fourth option (placement in escrow during an appeal) that would maintain due process and preserve the monies for whomever prevails.	
20	2/17/2023	BMS should not limit a provider recovery on appeal to only the disallowance, and instead allow for payment to be made to the Provider if they have been underpaid. The proposed language currently has the clause “not to exceed the disallowance amount determined in the DDR decision”. This would preclude payment to a provider that successfully shows on appeal that he or she was underpaid a certain amount during a disallowance appeal. While this may be a remote situation, the proposed language nonetheless would preclude that from occurring. Instead, should replace that clause with a sentence that allows for payment when it is determined the provider has been underpaid.	BMS will adopt this change.