



Senate

General Assembly

January Session, 2005

File No. 672

Senate Bill No. 21

Senate, May 4, 2005

The Committee on Appropriations reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-99 of the general statutes is amended by
2 adding subsection (d) as follows (*Effective July 1, 2005*):

3 (NEW) (d) The Commissioner of Social Services, or any entity with
4 whom the commissioner contracts, for the purpose of conducting an
5 audit of a service provider that participates as provider of services in a
6 program operated or administered by the department pursuant to
7 chapter 319s, 319t, 319v, 319y or 319ff, shall conduct any such audit in
8 accordance with the provisions of this subsection. For purposes of this
9 subsection "provider" means a person, public agency, private agency
10 or proprietary agency that is licensed, certified or otherwise approved
11 by the commissioner to supply services authorized by the programs set
12 forth in said chapters.

13 (1) Not less than thirty days prior to the commencement of any such
14 audit, the commissioner, or any entity with whom the commissioner
15 contracts to conduct an audit of a participating provider, shall provide
16 written notification of the audit to such provider.

17 (2) Any such audit shall be limited in scope to claims during the
18 period commencing one calendar year prior to the date of the written
19 notice provided pursuant to subdivision (1) of this subsection and
20 ending on the date of such notice and shall not exceed more than one
21 hundred claims for such period of time.

22 (3) Any clerical error, including, but not limited to, recordkeeping,
23 typographical, scrivener's or computer error, discovered in a record or
24 document produced for any such audit, shall not of itself constitute a
25 wilful violation of program rules unless proof of intent to commit
26 fraud or otherwise violate program rules is established.

27 (4) A finding of overpayment or underpayment to a provider in
28 program operated or administered by the department pursuant to
29 chapter 319s, 319t, 319v, 319y or 319ff, shall not be based on
30 extrapolated projections unless the commissioner makes a written
31 determination that (A) there is a sustained or high level of payment
32 error involving the provider, or (B) documented educational
33 intervention by the department has failed to correct the level of
34 payment error.

35 (5) A provider, in complying with the requirements of any such
36 audit, shall be allowed not less than thirty days to provide
37 documentation in connection with any discrepancy discovered and
38 brought to the attention of such provider in the course of any such
39 audit.

40 (6) The commissioner, or any entity with whom the commissioner
41 contracts, for the purpose of conducting an audit of a provider of any
42 of the programs operated or administered by the department pursuant
43 to chapter 319s, 319t, 319v, 319y or 319ff, shall produce a preliminary
44 written report concerning any audit conducted pursuant to this

45 subsection, and such preliminary report shall be provided to the
46 provider that was the subject of the audit, not more than thirty days
47 after the conclusion of such audit.

48 (7) The Department of Social Services shall establish an
49 administrative process that allows a provider to obtain a review and
50 appeal of any preliminary written report issued pursuant to
51 subdivision (6) of this subsection. Such review and appeal shall be
52 conducted by an ad hoc peer review panel, appointed by the
53 Commissioner of Social Services, that consists of not less than three
54 other service providers. If the ad hoc peer review panel concludes that
55 all findings contained in the preliminary written report are
56 unsubstantiated, then the department shall dismiss the preliminary
57 written report and there shall be no further proceedings in connection
58 with any such audit.

59 (8) Except in cases where a preliminary report is dismissed, in
60 accordance with the provisions of subdivision (7) of this subsection,
61 the commissioner, or any entity with whom the commissioner
62 contracts, for the purpose of conducting an audit of a service provider,
63 shall produce a final written report concerning any audit conducted
64 pursuant to this subsection. Such final written report shall be provided
65 to the provider that was the subject of the audit, not more than ninety
66 days after the date of issuance of the preliminary written report
67 provided for in subdivision (6) of this subsection, or in cases where
68 review and appeal is sought pursuant to subdivision (7) of this
69 subsection, not more than ninety days after the date a final written
70 decision is issued by the ad hoc peer review panel.

71 (9) The provisions of this subsection shall not apply to any audit
72 conducted by the Medicaid Fraud Control Unit established within the
73 Office of the Chief State's Attorney.

74 Sec. 2. Section 17b-245b of the general statutes is repealed and the
75 following is substituted in lieu thereof (*Effective July 1, 2005*):

76 (a) The Commissioner of Social Services shall, consistent with

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Social Services, Dept.	GF - See Below

Municipal Impact: None

Explanation

This bill makes numerous changes to the audit procedures of the Department of Social Services (DSS). These changes include limiting audits to the previous calander year, limiting the audit to 100 claims, and limiting the extrapolation of audit results. To the extent that these changes reduce the audit authority of the department, a reduction in the recoupmnt of overpayments may result. The bill further changes the manner in which rates for federally qualified health centers are calculated. The impact of this change will be dependent upon the cost reports submitted to the department.

OLR Bill Analysis

SB 21

**AN ACT CONCERNING AUDITS CONDUCTED BY THE
DEPARTMENT OF SOCIAL SERVICES****SUMMARY:**

This bill establishes a statutory procedure for Department of Social Services (DSS) audits of service providers. It limits audits to covering a one-year period and no more than 100 claims, prohibits extrapolations in calculating overpayments or underpayments, and makes clerical errors *per se* not violations.

The bill also requires the DSS commissioner to permit a federally qualified health center (FQHC) to submit a Medicaid cost report annually to DSS. It requires the commissioner, upon DSS's approval of the cost report, to adjust the FQHC's reimbursement rate by an amount equal to the percentage change in the approved report. If an FQHC does not submit a report, the bill requires the commissioner to adjust its rate in accordance with federal law. FQHCs are community health centers that receive federal funding and meet certain federal criteria, including a commitment to serving the poor and underinsured.

EFFECTIVE DATE: July 1, 2005

AUDIT PROCEDURES, LIMITS, AND NOTICES***Audit Scope***

The bill requires the DSS commissioner, or any audit agencies she uses to conduct service provider audits, to conduct the audits in accordance with this bill. The bill applies to the department's welfare programs such as Temporary Family Assistance, the State Supplement Program, Food Stamps; State-Administered General Assistance; Medicaid; the Connecticut Pharmaceutical Contract to the Elderly and Disabled; and long-term care programs such as nursing homes, residential care homes, and home and community-based care programs. For this purpose, a "provider" is a person or a public, private, or proprietary

agency licensed, certified, or otherwise approved by the commissioner to provide services authorized under the programs.

The bill requires the commissioner or the audit agency, at least 30 days before beginning the audit, to give written notice of the audit to the provider. The audit must be restricted to claims during the period beginning one calendar year before the date of the written notice and ending on the notice date. The bill limits the audit to covering no more than 100 claims for this period.

Clerical Errors

Under the bill, a clerical error discovered in a record or document produced for the audit, of itself, does not constitute a willful violation of program rules, unless proof of an intent to commit fraud or otherwise violate program rules is established. The bill defines a “clerical error” as including recordkeeping, typographical, writer’s, or computer error.

Extrapolation

The bill prohibits DSS from finding that an overpayment or underpayment was made to a provider based on extrapolated projections, unless (1) the commissioner determines in writing that the provider has a sustained or high level of payment error or (2) the department’s documented educational intervention has failed to correct the level of payment error. Extrapolation is the practice of (1) dividing the total number of payment errors found in a sample of documents by the sample size to arrive at average errors per sample and (2) multiplying this by the total number of claims to arrive at a presumed, extrapolated number of payment errors for all payments to the provider during the audited time period, on which the provider must make repayments to DSS.

Provider’s Right to Document Discrepancies

The bill requires a provider, in complying with audit requirements, to be given at least 30 days to provide documentation related to a discrepancy discovered during an audit.

PRELIMINARY REPORT

The bill requires the commissioner or the audit agency to produce a

preliminary written report concerning the audit and give it to the provider within 30 days after the audit's conclusion.

It requires DSS to establish an administrative process that allows a provider to obtain a review and appeal of a preliminary report. The review and appeal must be conducted by an *ad hoc* peer review panel appointed by the DSS commissioner and consisting of at least three other service providers. If the panel concludes that the preliminary findings are unsubstantiated, the bill requires DSS to dismiss the preliminary report and initiate no further proceedings in connection with the audit.

FINAL REPORT

Except in cases where the preliminary report is dismissed, the commissioner or auditing agency must produce a final written report and give it to the provider within 90 days after the preliminary report was issued or, if the provider sought a review and appeal, within 90 days after the peer review panel issues its final written decision.

EXEMPTION FROM BILL'S PROVISIONS

The bill's audit provisions do not apply to audits conducted by the Office of the Chief State's Attorney's Medicaid Fraud Control Unit.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference

Yea 17 Nay 0

Appropriations Committee

Joint Favorable Report

Yea 49 Nay 0