

OFFICE OF LEGISLATIVE RESEARCH  
PUBLIC ACT SUMMARY



**PA 13-293**—sHB 6514

*Program Review and Investigations Committee  
Human Services Committee*

**AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE  
PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE  
CONCERNING MEDICAID PAYMENT INTEGRITY**

**SUMMARY:** Starting January 1, 2015, this act requires the Department of Social Services (DSS) commissioner, in coordination with the chief state's attorney and attorney general, to annually submit a report to the Human Services and Appropriations committees on the state's efforts in the previous fiscal year to (1) prevent and control fraud, abuse, and errors in the Medicaid payment system and (2) recover Medicaid overpayments. Each agency must also post the report on its website.

The act also requires DSS to (1) assess the feasibility of expanding its Medicaid audit program and (2) analyze its third party liability system and report its findings to the committees by January 1, 2014.

EFFECTIVE DATE: Upon passage

**MEDICAID FRAUD PREVENTION AND OVERPAYMENT RECOVERY  
REPORT**

The act requires the annual report to include a final reconciled and unduplicated accounting of identified, ordered, collected, and outstanding Medicaid recoveries from all sources. The report (1) cannot include any personally identifying information related to a Medicaid claim or payment and (2) does not have to include information that is protected from disclosure by state or federal law or court rule.

The act requires DSS, the chief state's attorney, and the attorney general to provide specified information and data, presumably in the report.

*DSS Information Requirements*

The act requires DSS to provide Medicaid audit and program integrity investigation data. The audit data must include the:

1. number of completed audits by provider type,
2. amount of overpayments identified and recovered due to the audits,
3. amount of avoided costs identified by the audits, and
4. number of audits that were referred to the chief state's attorney.

The Medicaid program integrity investigation data must include:

1. the number of complaints received by source type and reason;
2. the number of investigations opened and completed by source and

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- provider type, including outcomes;
3. the amount of overpayments identified and collected due to investigations;
  4. the number of investigations resulting in (a) a referral to the chief state's attorney, (b) suspension of Medicaid payments by provider type, and (c) enrollment suspensions by provider type;
  5. for each closed investigation, the length of time between case opening and closing by time ranges, from between (a) less than one month to six months, (b) seven to 12 months, (c) 13 to 24 months, and (d) 25 or more months; and
  6. for each investigation referred to another agency, the length of time between case opening and referral for the above time ranges.

The act also requires DSS to provide information on the amount of overpayments recovery contractors collect, by contractor type.

### *Chief State's Attorney and Attorney General Information Requirements*

The act requires the chief state's attorney and attorney general to each provide Medicaid information including:

1. the number of investigations opened by source type;
2. the general nature of the allegations by provider type;
3. for each closed case, the length of time between case opening and closing by the aforementioned time ranges;
4. the final disposition category of closed cases by provider type;
5. the monetary recovery sought and collected by action, including (a) criminal charges (chief state's attorney) or civil monetary penalties (attorney general), (b) settlements, and (c) judgments; and
6. the number of referrals declined and the reasons why they were declined.

### *Report Requirements*

Medicaid is generally the payer of last resort. Thus, DSS must exhaust other payment sources (e.g., private insurance) before paying for health care services provided to Medicaid recipients. The report must include third-party liability (TPL) recovery information for the previous three-year period by fiscal year, including:

1. the total number of claims selected for billing by commercial health insurance and Medicare;
2. the total amount billed for such claims;
3. the number of claims where recovery occurred and the amount collected;
4. an explanation of any claim denials by category;
5. the number of files updated with third-party insurance information; and
6. the estimated future cost avoidance related to updated files.

The report must also include:

1. detailed and unit-specific performance standards, benchmarks, and metrics;
2. projected cost savings for the following fiscal year; and
3. new initiatives taken to prevent and detect overpayments.

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### DSS MEDICAID AUDIT PROGRAM EXPANSION AND TPL ASSESSMENTS

The act requires DSS to assess the feasibility of expanding its Medicaid audit program, including the possible use of contingency-based contractors.

The act requires DSS to produce a written analysis of the recovery of Medicaid dollars through its TPL contractors to determine if recovery procedures maximize collection efforts.

By January 1, 2014, DSS must submit a report on its audit feasibility assessment and TPL analysis findings to the Human Services and Appropriations committees.

OLR Tracking: KGD:RC:JKL:RO