



House of Representatives

General Assembly

File No. 674

February Session, 2014

Substitute House Bill No. 5500

House of Representatives, April 24, 2014

The Committee on Appropriations reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

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

1 Section 1. Subsection (d) of section 17b-99 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective July*
3 *1, 2014*):

4 (d) The Commissioner of Social Services, or any entity with which
5 the commissioner contracts, for the purpose of conducting an audit of
6 a service provider that participates as a provider of services in a
7 program operated or administered by the department pursuant to this
8 chapter or chapter 319t, 319v, 319y or 319ff, except a service provider
9 for which rates are established pursuant to section 17b-340, shall
10 conduct any such audit in accordance with the provisions of this
11 subsection. For purposes of this subsection "extrapolation" means the
12 determination of an unknown value by projecting the results of the
13 review of a sample of the universe from which the sample was drawn;
14 "medical necessity" has the same meaning as provided in section 17b-

15 259b; "provider" means a person, public agency, private agency or
16 proprietary agency that is licensed, certified or otherwise approved by
17 the commissioner to supply services authorized by the programs set
18 forth in said chapters; and "universe" means a defined population of
19 claims submitted by a provider during a specific time period.

20 (1) The Commissioner of Social Services, or any entity with which
21 the commissioner contracts for the purpose of conducting an audit of a
22 service provider pursuant to this subsection, shall have access during a
23 provider audit only to information relevant to the audit, including, but
24 not limited to, information concerning: (A) Services and goods
25 provided and billed to the Medicaid program during the time period
26 covered by the audit, (B) medical necessity of such services and goods
27 provided, and (C) whether the provider billed responsible third parties
28 for such services or goods provided. Nothing in this subsection shall
29 be construed as authorizing access to any information that is
30 confidential or prohibited from disclosure by law. Not less than thirty
31 days prior to the commencement of any such audit, the commissioner,
32 or any entity with which the commissioner contracts to conduct an
33 audit of a participating provider, shall provide written notification of
34 the audit to such provider, unless the commissioner, or any entity with
35 which the commissioner contracts to conduct an audit of a
36 participating provider makes a good faith determination that [(A)] the
37 health or safety of a recipient of services is at risk [;] or [(B)] the
38 provider is engaging in vendor fraud. A copy of the regulations
39 established pursuant to subdivision (11) of this subsection shall be
40 appended to such notification.

41 (2) Any clerical error, including, but not limited to, recordkeeping,
42 typographical, scrivener's or computer error, discovered in a record or
43 document produced for any such audit shall not of itself constitute a
44 wilful violation of program rules unless proof of intent to commit
45 fraud or otherwise violate program rules is established. In determining
46 which providers shall be subject to audits, the Commissioner of Social
47 Services shall first select providers with a higher compliance risk based
48 on past audits or errors.

49 (3) A finding of overpayment or underpayment to a provider in a
50 program operated or administered by the department pursuant to this
51 chapter or chapter 319t, 319v, 319y or 319ff, except a provider for
52 which rates are established pursuant to section 17b-340, shall not be
53 based on extrapolated projections unless (A) there is a sustained or
54 high level of payment error involving the provider, or (B) documented
55 educational intervention has failed to correct the level of payment
56 error [, or (C) the value of the claims in aggregate exceeds one hundred
57 fifty thousand dollars on an annual basis] involving the provider.

58 (4) A provider, in complying with the requirements of any such
59 audit, shall be allowed not less than thirty days to provide
60 documentation in connection with any discrepancy discovered and
61 brought to the attention of such provider in the course of any such
62 audit.

63 (5) The commissioner, or any entity with which the commissioner
64 contracts, for the purpose of conducting an audit of a provider of any
65 of the programs operated or administered by the department pursuant
66 to this chapter or chapter 319t, 319v, 319y or 319ff, except a service
67 provider for which rates are established pursuant to section 17b-340,
68 shall produce a preliminary written report concerning any audit
69 conducted pursuant to this subsection, and such preliminary report
70 shall be provided to the provider that was the subject of the audit not
71 later than sixty days after the conclusion of such audit.

72 (6) The commissioner, or any entity with which the commissioner
73 contracts, for the purpose of conducting an audit of a provider of any
74 of the programs operated or administered by the department pursuant
75 to this chapter or chapter 319t, 319v, 319y or 319ff, except a service
76 provider for which rates are established pursuant to section 17b-340,
77 shall, following the issuance of the preliminary report pursuant to
78 subdivision (5) of this subsection, hold an exit conference with any
79 provider that was the subject of any audit pursuant to this subsection
80 for the purpose of discussing the preliminary report. Such provider
81 may present evidence at such exit conference refuting findings in the

82 preliminary report.

83 (7) The commissioner, or any entity with which the commissioner
84 contracts, for the purpose of conducting an audit of a service provider,
85 shall produce a final written report concerning any audit conducted
86 pursuant to this subsection. Such final written report shall be provided
87 to the provider that was the subject of the audit not later than sixty
88 days after the date of the exit conference conducted pursuant to
89 subdivision (6) of this subsection, unless the commissioner, or any
90 entity with which the commissioner contracts, for the purpose of
91 conducting an audit of a service provider, agrees to a later date or
92 there are other referrals or investigations pending concerning the
93 provider.

94 (8) Any provider aggrieved by a decision contained in a final
95 written report issued pursuant to subdivision (7) of this subsection
96 may, not later than thirty days after the receipt of the final report,
97 request, in writing, a review on all items of aggrievement. Such request
98 shall contain a detailed written description of each specific item of
99 aggrievement. The designee of the commissioner who presides over
100 the review shall be impartial and shall not be an employee of the
101 Department of Social Services Office of Quality Assurance or an
102 employee of an entity with which the commissioner contracts for the
103 purpose of conducting an audit of a service provider. Following
104 review on all items of aggrievement, the designee of the commissioner
105 who presides over the review shall issue a final decision.

106 (9) A provider may appeal a final decision issued pursuant to
107 subdivision (8) of this subsection to the Superior Court in accordance
108 with the provisions of chapter 54.

109 (10) The provisions of this subsection shall not apply to any audit
110 conducted by the Medicaid Fraud Control Unit established within the
111 Office of the Chief State's Attorney.

112 (11) The commissioner shall adopt regulations, in accordance with
113 the provisions of chapter 54, to carry out the provisions of this

114 subsection and to ensure the fairness of the audit process, including,
 115 but not limited to, the sampling methodologies associated with the
 116 process. The commissioner shall provide free training to providers on
 117 how to enter claims to avoid clerical errors and shall post information
 118 on the department's Internet web site concerning the auditing process
 119 and methods to avoid clerical errors. Not later than October 1, 2014,
 120 the commissioner shall (A) convene a meeting with representatives of
 121 the dental profession concerning billing, record-keeping procedures
 122 and standards of such profession and any modifications in the
 123 auditing process concerning dental providers that may be necessary
 124 and federally permissible, and (B) ensure that the Department of Social
 125 Services, or any entity with which the commissioner contracts to
 126 conduct an audit pursuant to this subsection, has on staff or consults
 127 with a medical or dental professional who is experienced in the
 128 treatment, billing and coding procedures used by the provider subject
 129 to audit during such audit.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2014	17b-99(d)

Statement of Legislative Commissioners:

In section 1(d)(3)(B), the phrase "involving the provider" was added for consistency with other language in the subdivision.

APP *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 \$	FY 16 \$
Resources of the General Fund	GF - Revenue Loss	Potential	Potential
Department of Social Services	GF - Cost	Potential	Potential

Municipal Impact: None

Explanation

The bill changes the methods by which the Department of Social Services (DSS) audits providers under the Medicaid program. These changes include limiting the information that DSS may access related to an audit and changes the priority of providers subject to audit. The bill also removes one of three situations where DSS may use extrapolation in the audit process for recovery of overpayments. Should these changes negatively impact recoveries under DSS's audit process, additional costs and revenue losses may occur

Over the past four years, DSS has averaged \$27 million annually in recoupments and cost avoidance due to its current auditing processes. It cannot be known in advance to what extent the changes in the bill may impact current auditing results. For purposes of illustration, each 10% reduction in audit results would cost \$2,700,000 annually. Depending upon the type of audit, recoupments are either returned to the department to offset expenditures or booked to the General Fund as revenue.

The bill further requires DSS to provide training on how to enter claims to avoid clerical errors. DSS already provides this information

during provider enrollment and update bulletins. There is no anticipated additional fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

sHB 5500

AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

SUMMARY:

This bill makes several changes in the Department of Social Services' (DSS) Medicaid provider audit process. Specifically, it:

1. limits the information the DSS commissioner or a DSS-contracted auditor may access during an audit of service providers;
2. limits the types of claims the commissioner and auditors may use to extrapolate the incidence of overpayments or underpayments based on clerical errors (i.e., determine an unknown value by projecting the results of a sample of claims a provider submitted during a specific time);
3. in determining which providers to audit, requires the DSS commissioner to select those with a higher compliance risk based on past audits; and
4. allows an audited provider to present evidence to the commissioner or an auditor to refute the audit's findings.

The bill also requires DSS to (1) provide free provider training on how to enter claims to avoid clerical error and (2) post information on its website about the auditing process and ways to avoid clerical errors.

By October 1, 2014, the bill additionally requires the DSS commissioner to (1) meet with dental profession representatives about billing, record-keeping procedures, dental profession standards, and any audit process modifications concerning dental providers that may be necessary and federally permissible and (2) ensure that DSS or any

DSS-contracted auditor, during an audit, has on staff or consults with a medical or dental professional experienced in the treatment, billing, and coding procedures of the provider being audited.

EFFECTIVE DATE: July 1, 2014

DSS SERVICE PROVIDER AUDITS

Limits on Information Access

The bill limits, to information relevant to the audit, the information the DSS commissioner or any entity with whom he contracts to audit a service provider can access during the audit. Such information includes (1) services and goods provided and billed to Medicaid during the period the audit covers, (2) the medical necessity (see BACKGROUND) of the services and goods, and (3) whether the provider billed responsible third parties for them. It does not include information that is confidential or illegal to disclose.

Provider Audit Prioritization and Claim Extrapolation

The bill requires the DSS commissioner to prioritize which service providers to audit. It does so by requiring him to first select providers with a higher compliance risk based on past audits or errors.

The bill also limits the circumstances in which DSS or a DSS-contracted auditor may base a finding of provider overpayment or underpayment on extrapolated projections. It does so by eliminating DSS' and the auditors' ability to base a finding of overpayment or underpayment on extrapolation in cases where the claims' aggregate value exceeds \$150,000 on an annual basis. As under existing law, the findings may be based on extrapolated projections if (1) there is a sustained or high level of payment error involving the provider, or (2) the provider has failed to correct the level of payment error despite documented educational intervention.

Evidence to Refute Audit Findings

By law, the DSS commissioner or any DSS-contracted auditor, after issuing a preliminary report, must hold an exit conference with an

audited provider to discuss the report. The bill allows the audited provider to present evidence at the exit conference to refute the report's findings.

BACKGROUND

Medical Necessity

"Medical necessity" means those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person's medical condition, including mental illness, or its effects, in order to attain or maintain the person's achievable health and independent functioning. The services must be consistent with generally accepted medical practice standards based on (1) credible scientific evidence published in recognized peer-reviewed medical literature, (2) physician-specialty society recommendations, (3) the views of physicians practicing in relevant clinical areas, and (4) any other relevant factors.

The services must also be:

1. clinically appropriate in terms of type, frequency, timing, extent, and duration and considered effective for the person's illness, injury, or disease;
2. not primarily for the convenience of the person, the person's health care provider, or other health care providers;
3. not more costly than alternative services at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury, or disease; and
4. based on an assessment of the person and his or her medical condition (CGS § 17b-259b).

Legislative History

The House referred the bill (File 355) to the Appropriations Committee, which reported a substitute removing a provision limiting the DSS commissioner's and any DSS-contracted auditor's use of

extrapolation to similar claims, including those billed under the same billing code.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 17 Nay 0 (03/20/2014)

Appropriations Committee

Joint Favorable Substitute

Yea 44 Nay 0 (04/15/2014)