



# House of Representatives

## File No. 714

General Assembly

February Session, 2014

**(Reprint of File Nos. 355 and 674)**

Substitute House Bill No. 5500  
As Amended by House Amendment  
Schedule "A"

Approved by the Legislative Commissioner  
April 30, 2014

### **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2 repealed and the following is substituted in lieu thereof (*Effective July*  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 to the universe from which the sample was drawn;  
14 "provider" means a person, public agency, private agency or

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

19 (1) Not less than thirty days prior to the commencement of any such  
20 audit, the commissioner, or any entity with which the commissioner  
21 contracts to conduct an audit of a participating provider, shall provide  
22 written notification of the audit to such provider, unless the  
23 commissioner, or any entity with which the commissioner contracts to  
24 conduct an audit of a participating provider makes a good faith  
25 determination that (A) the health or safety of a recipient of services is  
26 at risk; or (B) the provider is engaging in vendor fraud. A copy of the  
27 regulations established pursuant to subdivision (11) of this subsection  
28 shall be appended to such notification.

29 (2) Any clerical error, including, but not limited to, recordkeeping,  
30 typographical, scrivener's or computer error, discovered in a record or  
31 document produced for any such audit shall not of itself constitute a  
32 wilful violation of program rules unless proof of intent to commit  
33 fraud or otherwise violate program rules is established. In determining  
34 which providers shall be subject to audits, the Commissioner of Social  
35 Services may give consideration to the history of a provider's  
36 compliance in addition to other criteria used to select a provider for an  
37 audit.

38 (3) A finding of overpayment or underpayment to a provider in a  
39 program operated or administered by the department pursuant to this  
40 chapter or chapter 319t, 319v, 319y or 319ff, except a provider for  
41 which rates are established pursuant to section 17b-340, shall not be  
42 based on [extrapolated projections] extrapolation unless (A) there is a  
43 determination of sustained or high level of payment error involving  
44 the provider, (B) documented educational intervention has failed to  
45 correct the level of payment error, or (C) the value of the claims in  
46 aggregate exceeds [one hundred fifty] two hundred thousand dollars  
47 on an annual basis.

48 (4) A provider, in complying with the requirements of any such  
49 audit, shall be allowed not less than thirty days to provide  
50 documentation in connection with any discrepancy discovered and  
51 brought to the attention of such provider in the course of any such  
52 audit.

53 (5) The commissioner, or any entity with which the commissioner  
54 contracts, for the purpose of conducting an audit of a provider of any  
55 of the programs operated or administered by the department pursuant  
56 to this chapter or chapter 319t, 319v, 319y or 319ff, except a service  
57 provider for which rates are established pursuant to section 17b-340,  
58 shall produce a preliminary written report concerning any audit  
59 conducted pursuant to this subsection, and such preliminary report  
60 shall be provided to the provider that was the subject of the audit not  
61 later than sixty days after the conclusion of such audit.

62 (6) The commissioner, or any entity with which the commissioner  
63 contracts, for the purpose of conducting an audit of a provider of any  
64 of the programs operated or administered by the department pursuant  
65 to this chapter or chapter 319t, 319v, 319y or 319ff, except a service  
66 provider for which rates are established pursuant to section 17b-340,  
67 shall, following the issuance of the preliminary report pursuant to  
68 subdivision (5) of this subsection, hold an exit conference with any  
69 provider that was the subject of any audit pursuant to this subsection  
70 for the purpose of discussing the preliminary report. Such provider  
71 may present evidence at such exit conference refuting findings in the  
72 preliminary report.

73 (7) The commissioner, or any entity with which the commissioner  
74 contracts, for the purpose of conducting an audit of a service provider,  
75 shall produce a final written report concerning any audit conducted  
76 pursuant to this subsection. Such final written report shall be provided  
77 to the provider that was the subject of the audit not later than sixty  
78 days after the date of the exit conference conducted pursuant to  
79 subdivision (6) of this subsection, unless the commissioner, or any  
80 entity with which the commissioner contracts, for the purpose of

81 conducting an audit of a service provider, agrees to a later date or  
82 there are other referrals or investigations pending concerning the  
83 provider.

84 (8) Any provider aggrieved by a decision contained in a final  
85 written report issued pursuant to subdivision (7) of this subsection  
86 may, not later than thirty days after the receipt of the final report,  
87 request, in writing, a review on all items of aggrievement. Such request  
88 shall contain a detailed written description of each specific item of  
89 aggrievement. The designee of the commissioner who presides over  
90 the review shall be impartial and shall not be an employee of the  
91 Department of Social Services Office of Quality Assurance or an  
92 employee of an entity with which the commissioner contracts for the  
93 purpose of conducting an audit of a service provider. Following  
94 review on all items of aggrievement, the designee of the commissioner  
95 who presides over the review shall issue a final decision.

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

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

102 (11) The commissioner shall adopt regulations, in accordance with  
103 the provisions of chapter 54, to carry out the provisions of this  
104 subsection and to ensure the fairness of the audit process, including,  
105 but not limited to, the sampling methodologies associated with the  
106 process. The commissioner shall provide free training to providers on  
107 how to enter claims to avoid clerical errors and shall post information  
108 on the department's Internet web site concerning the auditing process  
109 and methods to avoid clerical errors. Not later than February 1, 2015,  
110 the commissioner shall establish and publish on the department's  
111 Internet web site audit protocols to assist the Medicaid provider  
112 community in developing programs to improve compliance with

113 Medicaid requirements under state and federal laws and regulations,  
114 provided audit protocols may not be relied upon to create a  
115 substantive or procedural right or benefit enforceable at law or in  
116 equity by any person, including a corporation. The commissioner shall  
117 establish audit protocols for specific providers or categories of service,  
118 including, but not limited to: (A) Licensed home health agencies, (B)  
119 drug and alcohol treatment centers, (C) durable medical equipment,  
120 (D) hospital outpatient services, (E) physician and nursing services, (F)  
121 dental services, (G) behavioral health services, (H) pharmaceutical  
122 services, and (I) emergency and nonemergency medical transportation  
123 services. The commissioner shall ensure that the Department of Social  
124 Services, or any entity with which the commissioner contracts to  
125 conduct an audit pursuant to this subsection, has on staff or consults  
126 with, as needed, a medical or dental professional who is experienced in  
127 the treatment, billing and coding procedures used by the provider  
128 being audited.

129       Sec. 2. Section 17b-99a of the 2014 supplement to the general statutes  
130 is repealed and the following is substituted in lieu thereof (*Effective July*  
131 *1, 2014*):

132       (a) (1) For purposes of this section, (A) "extrapolation" means the  
133 determination of an unknown value by projecting the results of the  
134 review of a sample to the universe from which the sample was drawn,  
135 (B) "facility" means any facility described in this subsection and for  
136 which rates are established pursuant to section 17b-340, and (C)  
137 "universe" means a defined population of claims submitted by a  
138 facility during a specific time period.

139       (2) The Commissioner of Social Services shall conduct any audit of a  
140 licensed chronic and convalescent nursing home, chronic disease  
141 hospital associated with a chronic and convalescent nursing home, a  
142 rest home with nursing supervision, a licensed residential care home,  
143 as defined in section 19a-490, and a residential facility for persons with  
144 intellectual disability which is licensed pursuant to section 17a-227 and  
145 certified to participate in the [Title XIX] Medicaid program as an

146 intermediate care facility for individuals with intellectual disabilities in  
147 accordance with the provisions of this section.

148 (b) Not less than thirty days prior to the commencement of any such  
149 audit, the commissioner shall provide written notification of the audit  
150 to such facility, unless the commissioner makes a good-faith  
151 determination that (1) the health or safety of a recipient of services is at  
152 risk; or (2) the facility is engaging in vendor fraud under sections 53a-  
153 290 to 53a-296, inclusive.

154 (c) Any clerical error, including, but not limited to, recordkeeping,  
155 typographical, scrivener's or computer error, discovered in a record or  
156 document produced for any such audit, shall not of itself constitute a  
157 wilful violation of the rules of a medical assistance program  
158 administered by the Department of Social Services unless proof of  
159 intent to commit fraud or otherwise violate program rules is  
160 established. In determining which facilities shall be subject to audits,  
161 the Commissioner of Social Services may give consideration to the  
162 history of a facility's compliance in addition to other criteria used to  
163 select a facility for an audit.

164 (d) A finding of overpayment or underpayment to such facility shall  
165 not be based on [extrapolated projections] extrapolation unless (1)  
166 there is a determination of sustained or high level of payment error  
167 involving the facility, (2) documented educational intervention has  
168 failed to correct the level of payment error, or (3) the value of the  
169 claims in aggregate exceeds [one hundred fifty] two hundred thousand  
170 dollars on an annual basis.

171 (e) A facility, in complying with the requirements of any such audit,  
172 shall be allowed not less than thirty days to provide documentation in  
173 connection with any discrepancy discovered and brought to the  
174 attention of such facility in the course of any such audit.

175 (f) The commissioner shall produce a preliminary written report  
176 concerning any audit conducted pursuant to this section and such  
177 preliminary report shall be provided to the facility that was the subject

178 of the audit not later than sixty days after the conclusion of such audit.

179 (g) The commissioner shall, following the issuance of the  
180 preliminary report pursuant to subsection (f) of this section, hold an  
181 exit conference with any facility that was the subject of any audit  
182 pursuant to this subsection for the purpose of discussing the  
183 preliminary report. Such facility may present evidence at such exit  
184 conference refuting findings in the preliminary report.

185 (h) The commissioner shall produce a final written report  
186 concerning any audit conducted pursuant to this subsection. Such final  
187 written report shall be provided to the facility that was the subject of  
188 the audit not later than sixty days after the date of the exit conference  
189 conducted pursuant to subsection (g) of this section, unless the  
190 commissioner and the facility agree to a later date or there are other  
191 referrals or investigations pending concerning the facility.

192 (i) Any facility aggrieved by a final report issued pursuant to  
193 subsection (h) of this section may request a rehearing. A rehearing  
194 shall be held by the commissioner or the commissioner's designee,  
195 provided a detailed written description of all items of aggrievement in  
196 the final report is filed by the facility not later than ninety days  
197 following the date of written notice of the commissioner's decision.  
198 The rehearing shall be held not later than thirty days following the  
199 date of filing of the detailed written description of each specific item of  
200 aggrievement. The commissioner shall issue a final decision not later  
201 than sixty days following the close of evidence or the date on which  
202 final briefs are filed, whichever occurs later. Any items not resolved at  
203 such rehearing to the satisfaction of the facility or the commissioner  
204 shall be submitted to binding arbitration by an arbitration board  
205 consisting of one member appointed by the facility, one member  
206 appointed by the commissioner and one member appointed by the  
207 Chief Court Administrator from among the retired judges of the  
208 Superior Court, which retired judge shall be compensated for his  
209 services on such board in the same manner as a state referee is  
210 compensated for his services under section 52-434. The proceedings of

211 the arbitration board and any decisions rendered by such board shall  
212 be conducted in accordance with the provisions of the Social Security  
213 Act, 42 USC 1396, as amended from time to time, and chapter 54.

214 (j) The submission of any false or misleading fiscal information or  
215 data to the commissioner shall be grounds for suspension of payments  
216 by the state under sections 17b-239 to 17b-246, inclusive, and sections  
217 17b-340 and 17b-343, in accordance with regulations adopted by the  
218 commissioner. In addition, any person, including any corporation,  
219 who knowingly makes or causes to be made any false or misleading  
220 statement or who knowingly submits false or misleading fiscal  
221 information or data on the forms approved by the commissioner shall  
222 be guilty of a class D felony.

223 (k) The commissioner, or any agent authorized by the commissioner  
224 to conduct any inquiry, investigation or hearing under the provisions  
225 of this section, shall have power to administer oaths and take  
226 testimony under oath relative to the matter of inquiry or investigation.  
227 At any hearing ordered by the commissioner, the commissioner or  
228 such agent having authority by law to issue such process may  
229 subpoena witnesses and require the production of records, papers and  
230 documents pertinent to such inquiry. If any person disobeys such  
231 process or, having appeared in obedience thereto, refuses to answer  
232 any pertinent question put to the person by the commissioner or the  
233 commissioner's authorized agent or to produce any records and papers  
234 pursuant thereto, the commissioner or the commissioner's agent may  
235 apply to the superior court for the judicial district of Hartford or for  
236 the judicial district wherein the person resides or wherein the business  
237 has been conducted, or to any judge of such court if the same is not in  
238 session, setting forth such disobedience to process or refusal to answer,  
239 and such court or judge shall cite such person to appear before such  
240 court or judge to answer such question or to produce such records and  
241 papers.

242 (l) The commissioner shall adopt regulations, in accordance with the  
243 provisions of chapter 54, to carry out the provisions of this section and

244 to ensure the fairness of the audit process, including, but not limited  
245 to, the sampling methodologies associated with the process. The  
246 commissioner shall provide free training to facilities on the preparation  
247 of cost reports to avoid clerical errors and shall post information on the  
248 department's Internet web site concerning the auditing process and  
249 methods to avoid clerical errors. Not later than April 1, 2015, the  
250 commissioner shall establish audit protocols to assist facilities subject  
251 to audit pursuant to this section in developing programs to improve  
252 compliance with Medicaid requirements under state and federal laws  
253 and regulations, provided audit protocols may not be relied upon to  
254 create a substantive or procedural right or benefit enforceable at law or  
255 in equity by any person, including a corporation. The commissioner  
256 shall establish and publish on the department's Internet web site audit  
257 protocols for: (1) Licensed chronic and convalescent nursing homes, (2)  
258 chronic disease hospitals associated with chronic and convalescent  
259 nursing homes, (3) rest homes with nursing supervision, (4) licensed  
260 residential care homes, as defined in section 19a-490, and (5)  
261 residential facilities for persons with intellectual disabilities that are  
262 licensed pursuant to section 17a-227 and certified to participate in the  
263 Medicaid program as intermediate care facilities for individuals with  
264 intellectual disabilities. The commissioner shall ensure that the  
265 Department of Social Services, or any entity with which the  
266 commissioner contracts to conduct an audit pursuant to this section,  
267 has on staff or consults with, as needed, licensed health professionals  
268 with experience in treatment, billing and coding procedures used by  
269 the facilities being audited pursuant to this section.

270 Sec. 3. (NEW) (*Effective July 1, 2014*) Not later than February 15,  
271 2015, the Commissioner of Social Services shall submit a report, in  
272 accordance with the provisions of section 11-4a of the general statutes,  
273 to the joint standing committee of the General Assembly having  
274 cognizance of matters relating to human services on the audit  
275 protocols and procedures established pursuant to section 17b-99 of the  
276 general statutes, as amended by this act, and progress concerning the  
277 audit protocols and procedures to be established pursuant to section

278 17b-99a of the general statutes, as amended by this act. Not later than  
279 February 15, 2016, the commissioner shall submit a report, in  
280 accordance with the provisions of section 11-4a of the general statutes,  
281 to the joint standing committee of the General Assembly having  
282 cognizance of matters relating to human services on the  
283 implementation of the audit protocols and procedures established  
284 pursuant to sections 17b-99 of the general statutes, as amended by this  
285 act, and 17b-99a of the general statutes, as amended by this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2014</i>	17b-99(d)
Sec. 2	<i>July 1, 2014</i>	17b-99a
Sec. 3	<i>July 1, 2014</i>	New section

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.

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### ***OFA Fiscal Note***

***State Impact:*** None

***Municipal Impact:*** None

### ***Explanation***

The bill changes certain criteria concerning the Department of Social Services' (DSS) selection of providers to audit. The bill also increases the threshold for the use of extrapolation from claims with an aggregate value of \$150,000 to claims with an aggregate value of \$200,000. Although these changes may alter the sample of providers who are audited, it is not anticipated to substantially change the recoveries that are realized under the current audit procedures.

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. The bill also requires DSS to establish and publish audit protocols and to report certain information to the General Assembly. These requirements are not anticipated to result in a fiscal impact.

House "A" struck the underlying bill and resulted in the fiscal impacts noted above.

### ***The Out Years***

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis**

**sHB 5500 (as amended by House "A")\***

***AN ACT CONCERNING PROVIDER AUDITS UNDER THE  
MEDICAID PROGRAM.***

**SUMMARY:**

This bill makes several changes to Department of Social Services' (DSS) processes for auditing (1) Medicaid providers and (2) facilities that receive Medicaid or other state payments (including nursing homes, residential care homes, and intermediate care facilities for people with intellectual disabilities). Specifically, it (1) limits the circumstances in which DSS may extrapolate audited claims and (2) allows an audited provider or facility to present evidence to the commissioner or an auditor to refute the audit's findings. For auditing purposes, it also requires DSS and DSS-contracted auditors to have on staff or consult with, as needed, health care providers experienced in relevant treatment, billing, and coding procedures.

The bill requires the DSS commissioner to adopt facility audit regulations to ensure fairness in the audit process, including associated sampling methodologies. The law already requires the commissioner to adopt such regulations for provider audits.

The commissioner must also establish and publish on the department website audit protocols to help providers and facilities comply with state and federal Medicaid laws and regulations. The audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by anyone, including a corporation.

The bill also (1) requires DSS to provide free training to providers and facilities to help them avoid clerical errors and (2) imposes

reporting requirements on DSS pertaining to the revised audit protocols and procedures.

\*House Amendment "A" principally:

1. increases, rather than eliminates, the minimum aggregate value of claims on which DSS may use extrapolation to determine overpayment or underpayment;
2. requires DSS to establish and post audit protocols and report to the Human Services Committee on its progress in implementing the bill's provisions;
3. eliminates the bill's (a) restrictions on the DSS commissioner's and auditors' access to information during a provider audit and (b) requirement that DSS meet with dental profession representatives about audit process modifications; and
4. allows, instead of requires, DSS to consider compliance history when determining which providers to audit.

EFFECTIVE DATE: July 1, 2014

## **CLAIM EXTRAPOLATION**

### ***Definitions***

Under the bill:

1. "extrapolation" means determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn and
2. "universe" means a defined population of claims submitted by a provider during a specific time period.

### ***Extrapolation Use***

Current law allows DSS or a DSS-contracted auditor to base a finding of provider or facility overpayment or underpayment on extrapolated projections if the claims' aggregate value exceeds

\$150,000 on an annual basis. The bill limits the circumstances in which DSS or an auditor may use extrapolation by increasing the minimum aggregate value of claims on which such method may be used to \$200,000 on an annual basis.

### **AUDIT PROCESS REVISIONS**

The bill allows the DSS commissioner, when determining which providers and facilities to audit, to consider a provider's or facility's compliance history in addition to other audit criteria.

The bill also requires the DSS commissioner to ensure that DSS or any DSS-contracted auditor, during an audit, has on staff or consults with, as needed, a licensed health professional experienced in the treatment, billing, and coding procedures of the provider or facility being audited.

By law, the DSS commissioner or any DSS-contracted auditor, after issuing a preliminary report, must hold an exit conference with an audited provider or facility to discuss the report. The bill allows the audited provider or facility to present evidence at the exit conference to refute the report's findings.

### **AUDIT PROTOCOLS**

#### ***Provider Protocols***

The bill requires the DSS commissioner, by February 1, 2015, to establish and publish on the department website protocols to assist the Medicaid providers to develop programs to improve Medicaid state and federal law and regulation compliance. The commissioner must establish specific audit protocols for licensed home health agencies, drug and alcohol treatment centers, durable medical equipment, and the following types of services: (1) hospital outpatient, (2) physician and nursing, (3) dental, (4) behavioral health, (5) pharmaceutical, and (6) emergency and nonemergency medical transportation.

#### ***Facility Protocols***

The bill requires the DSS commissioner, by April 1, 2015, to

establish audit protocols to assist facilities subject to audit to develop programs to improve Medicaid state and federal law and regulation compliance. The commissioner must establish and publish on its website audit protocols for:

1. licensed chronic and convalescent nursing homes and associated chronic disease hospitals,
2. rest homes with nursing supervision,
3. licensed residential care homes, and
4. licensed and certified intermediate care facilities for people with intellectual disabilities.

**PROVIDER AND FACILITY TRAINING**

The bill requires DSS to (1) help facilities and providers avoid clerical errors by providing free training to (a) providers on how to enter claims and (b) facilities on cost report preparation and (2) post information on its website about the auditing process and ways to avoid clerical errors.

**DSS REPORTING REQUIREMENTS**

The bill requires the DSS commissioner to report to the Human Services Committee (1) by February 1, 2015 on the department’s progress concerning the audit protocols and procedures and (2) by February 1, 2016 on their implementation.

**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)