



RODERICK L. BREMBY  
Commissioner

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
OFFICE OF THE COMMISSIONER

TELEPHONE  
(860) 424-5053

TDD/TTY  
1-800-842-4524

FAX  
(860) 424-5057

EMAIL  
[commis.dss@ct.gov](mailto:commis.dss@ct.gov)

MEMORANDUM

To: Individuals Who Commented on the Proposed Regulation Regarding  
the Audit of Providers, DSS Reg. No. 11-13JM

From: Roderick L. Bremby, Commissioner   
Department of Social Services  
25 Sigourney St.  
Hartford, CT 06106

Date: May 22, 2013

Re: Responses to Public Comment

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The following are the Department of Social Services' ("the Department") responses to comments received from the public. The Notice of Intent for this regulation was published in the Connecticut Law Journal on October 16, 2012. A copy of the regulation with revisions based on public comment is enclosed. The Department anticipates submitting the proposed regulation to the Legislative Regulation Review Committee by August 1, 2013.

**General Comments:**

- 1) **Comment:** The regulations do not evidence the transparency and accountability statutorily required to ensure the fairness of the audit process due to the department's frequent use of the term "in the department's discretion."

**Response:** The term "in the department's discretion" is appropriate and necessary to ensure the auditing process is not unduly restricted. The Department fully attempts to be as transparent as it can be without inhibiting the auditing process. Finally, the regulations comply with all statutory requirements.

- 2) **Comment:** A commenter requested that the regulations describe the safeguards the Department has put in place to ensure that all health information is protected in accordance with HIPAA.

**Response:** The Department does not feel this is necessary as the Department is a HIPAA covered agency and is already required to follow all HIPAA requirements.

- 3) **Comment:** A commenter noted that Connecticut General Statute ("CGS") section 17b-99 allows the Commissioner or "any entity with which the Commissioner contracts for the purpose of conducting an audit" to conduct an audit. The commenter requested that

the Department add a provision to the regulations that defines the qualifications of an entity with which the Commissioner may contract.

**Response:** It is not necessary to define the qualifications of an entity with which the Commissioner may contract because the Commissioner contracts only with qualified entities.

- 4) **Comment:** A commenter requested that these regulations should apply to CGS 17b-99a, which governs the audits of nursing homes, residential care homes and other providers whose rates are determined under CGS 17b-340. The commenter then had several requests if the regulations were to apply to CGS 17b-99a.

**Response:** CGS 17b-99 covers the audits of service providers, except a service provider for which rates are established pursuant to CGS 17b-340. In contrast, CGS 17b-99a covers the audits of long-term care facilities for which rates are established pursuant to CGS 17b-340. Therefore, these regulations would not apply to CGS 17b-99a as they cover different types of audits.

- 5) **Comment:** A commenter requested that if a provider is audited by any other government agency or contractor (RAC, MIC, or the Department itself) then the Department should not include those items/claims which have already been audited, in the Department's audit.

**Response:** The Department coordinates the selection of providers being audited to prevent duplication of activities. It is possible that a claim could be reviewed by multiple parties. In this scenario, each review must have a dissimilar purpose.

- 6) **Comment:** A commenter stated that the audits governed by these regulations are deficient because many of the Department's regulations, policy manuals, and policy bulletins are out of date.

**Response:** The Department disagrees with this comment. The Department's regulations, policy manuals, and policy bulletins remain valid and in use by the Department.

#### **Comments on 17b-99-1 (Scope):**

- 1) **Comment:** A commenter requested a statement of law in the regulation that informs the reader that any conflict between the regulations and the statute should be resolved in favor of the statute.

**Response:** This is unnecessary as this is a matter of the law.

- 2) **Comment:** A commenter requested the following language be added to the regulations: "The commissioner, or any entity with which the commissioner contracts, for the purposes of conducting an audit of provider, shall consider a provider's explanation of compliance with laws and/or regulations when determining overpayments or

underpayments to a provider. A provider may raise, at any time, including as an item of grievance, that its compliance with a state or federal law or regulation explains or negates a negative finding on audit.”

**Response:** This language is not necessary. The Department already considers any explanations given by the provider regarding its compliance with laws and/or regulations. There are mechanisms in place for providers to give their explanations during the audit, for example, at the audit exit conference or in the form of an item of grievance when requesting an audit review.

- 3) **Comment:** A commenter requested that the scope section clarify that these regulations do not apply to the audit of cost report filings that are used to establish payment rates under the Medicaid program. The audit of cost reports is governed by CGS 17b-99a.

**Response:** We agree with the commenter that these regulations do not apply to CGS 17b-99a. These regulations apply only to CGS 17b-99. It is not necessary to add this to the scope section as the scope section already states that these regulations set forth the Department’s general requirements for auditing providers pursuant to CGS 17b-99.

#### **Comments on 17b-99-2 (Definitions):**

1) **General Comments:**

- a. **Comment:** A commenter requested the following terms be added to the definitions section: “underpayment,” “error rate,” and “accurate and complete.” Provider suggests these terms address the possibility of minor errors and omissions of an immaterial or de minimus nature.

**Response:** We agree that a definition of underpayment should be added and have added that in the current draft. Definitions for “error rate” and “accurate and complete,” however, are not necessary for these regulations.

- b. **Comment:** A commenter requested that terms like “claim” and “error” be defined depending on the type of provider being audited. Commenter requested that the Department should issue and publish periodic policy transmittals advising providers of these definitions as they relate to different types of providers.

**Response:** Defining these types of terms for each type of provider being audited could unduly restrict the auditing process due to the large variety of claims and providers. The current definitions are meant to encompass all providers. Additionally, the Department cannot expand the regulation and definitions through the use of policy transmittals.

- c. **Comment:** A commenter noted that according to the definitions, the basis for recovery of monies is limited to overpayments whereas in the past, DSS has monetized errors that are not actually overpayments such as failure to get a signature or other clerical errors.

**Response:** Based on this comment, the Department has revised the definition of overpayment.

2) Subsection (1):

- a. **Comment:** A commenter requested that the definition of “audit” identify a time period for audits.

**Response:** This is not necessary as the time period or “look back” period for audits will go back no further than the document retention period specified in the provider enrollment agreement or as provided by applicable law.

- b. **Comment:** A commenter requested that the definition of “audit” cover cost report audits, credit balance and third party liability audits.

**Response:** This regulation does not cover cost report audits. Therefore, it is not necessary to include this in the definition of “audit.” Credit balance and third party liability audits are different types of reviews and do not fall under the definition of “audit.”

3) Subsection (2):

- a. **Comment:** A commenter requested that the department clarify what a claim is for each industry.

**Response:** Defining a claim for each type of provider being audited could unduly restrict the auditing process due to the large variety of claims and providers. The current definitions are meant to encompass all providers.

4) Subsection (3):

- a. **Comment:** Several commenters noted that the definition of “clerical error” in the regulation differs from the definition in Connecticut General Statute (“CGS”) 17b-99(d)(2) by adding the words “discrete” and “isolated” in the definition. The provider requests that these words be removed from the regulation to ensure the protection offered by the statute in reference to clerical errors.

**Response:** There is no definition of “clerical error” in CGS 17b-99(d)(2) or anywhere else in CGS 17b-99. Therefore the definition of “clerical error” in the regulation does not differ from the statute. Additionally, the proposed definition is being provided at the request of the provider community.

5) Subsection (6):

- a. **Comment:** A commenter suggested that the definition of “commissioner’s designee” should specifically reference CGS 17b-99(d)(8).

**Response:** This is not necessary as the definition of “commissioner’s designee” already references CGS 17b-99.

6) Subsection (7):

- a. **Comment:** A commenter requested that the word “agent” in the definition of “department” be defined.

**Response:** The Department does not believe it is necessary to define the word “agent” in the definition of “department.” The word “agent” speaks for itself.

7) Subsection (8):

- a. **Comment:** A commenter would like the definition of “documents or records” expanded because currently, it does not include any data created after the date of the submission of the claim or created after an audit has begun, unless the department finds such documents or records created after the fact reliable for the purpose of the audit. The Provider argues that psychological testing and developmental evaluations, among other things, requires time to complete the comprehensive report and therefore is completed after claims are submitted.

**Response:** A claim should not be submitted to the Department until all documentation for that claim is complete. There should be adequate and contemporaneous documentation submitted to support each claim made. Therefore, we believe the Department’s definition is adequate.

- b. **Comment:** A commenter requested that the Department issue written findings regarding whether post-claims data presented by the provider is “reliable” for purposes of considering it in the audit. Commenter suggests that this may be important for establishing an administrative record if the provider appeals to the Superior Court.

**Response:** A provider may request written findings, regarding whether the Department found post-claims data “reliable” for audit consideration, as part of the audit review process.

8) Subsection (11):

- a. **Comment:** A commenter disagreed with the department’s definition of extrapolation, stating that it does not address the “purpose” of extrapolation. The provider suggested that the definition should focus on projecting the results of the review of a sample selection to the universe and states that minor errors and omissions of an immaterial or de minimus nature should not be included in the calculation.

**Response:** The Department believes that the current definition of “extrapolation” is accurate and consistent with the definition of “extrapolation” used by the professional auditing and accounting professions.

- b. **Comment:** A commenter stated that the definition of “extrapolation” does not require the word “unknown” before value.

**Response:** The Department disagrees with this assertion. The word “unknown” is included in other definitions of “extrapolation” including the definition of “extrapolation” by Black’s Law Dictionary.

9) Subsection (12):

- a. **Comment:** A commenter stated that the definition of “goods or services” is problematic in that it potentially includes both conditions of payment (such as using the correct billing code) with conditions of participation (such as maintaining appropriate staffing levels under a licensure requirement). Commenter suggests that courts have held that overpayment recoveries can only be based on a provider’s failure to satisfy a condition of payment, and not a condition of participation. Commenter suggests that this definition allows the Department to recover overpayments based on a finding of noncompliance with any requirement regardless of whether the requirement relates to billing or the provision of a covered service.

**Response:** The Department does consider conditions of participation a condition of payment. The Department can recover overpayments based on a finding of noncompliance with any requirement of law regardless of whether the requirement relates to billing or the provision of a covered service.

10) Subsection (14):

- a. **Comment:** A commenter suggested the Department remove the definition for “medical record” because the term is not used in the proposed regulations, the definition is too narrow, and the terms “records” and “documents” are defined in proposed Section 17b-99-2(8) and already cover medical records.

**Response:** The Department agrees with the provider and will remove the definition of “medical records” as the term is not used in the regulation.

11) Subsection (15):

- a. **Comment:** A commenter requested that the phrase “or a violation due to abuse or fraud” be removed from the definition of “overpayment.”

**Response:** The Department agrees that this language should be removed from the definition of “overpayment” and has revised this definition.

12) Subsection (21):

- a. **Comment:** A commenter requested that the definition of “sample design” be more specific in the method used to select the sample unit. The commenter wanted to know how the sample is actually selected.

**Response:** The Department disagrees that the definition of “sample design” should be more specific. The methods used to select the sample units could

change and the Department needs flexibility in the methods it chooses. Making the definition more specific could unduly restrict the auditing process.

13) Subsection (23):

- a. **Comment:** A commenter requested clarification on what other units of measurement the department might use when the department defines a “sample unit” as one paid claim or a different unit of measurement when a different unit is deemed necessary by the Department.

b.

**Response:** If a specific unit of measurement is deemed necessary by the Department, the Department will explain that specific unit of measurement in its audit report. Therefore, it is not necessary to clarify the definition of “sample unit.” To do so could unduly restrict the auditing process as the Department needs flexibility for any circumstances that would require a specific unit of measurement for a sample unit.

**Comments on Section 17b-99-3 (Sampling Methodology):**

1) General Comments:

- a. **Comment:** Several commenters stated that sampling needs to be statistically valid.

**Response:** All sampling used by the Department will be statistically valid.

- b. **Comment:** Several commenters stated that statistical sampling and extrapolation should not be used on claims across different universes and completely different services as it can result in unfair results.

c.

**Response:** The Department utilizes adequate analysis to ensure an appropriate sample design.

- d. **Comment:** A commenter requested that the following language from the original law be included in the regulations: “Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener’s or computer error, discovered in a record or document produced for any such audit shall not of itself constitute a willful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established.”

**Response:** This language is already included in CGS 17b-99.

- e. **Comment:** A commenter requested that the provider have the opportunity to inspect the samples chosen to audit, so that it can be determined whether the sample is statistically sound.

**Response:** The provider has the opportunity to challenge the statistical validity of the sample throughout the auditing process.

2) Subsection (a):

- a. **Comment:** Several commenters argued that extrapolation is not permitted by statute unless and until the prerequisites of 17b-99(d)(3) are met. One commenter would like the following language in the regulation: "A finding of overpayment or underpayment to a provider shall not be based on extrapolation projections unless one of the statutory prerequisites set forth in Section 17b-99(d)(3) of the Connecticut General Statutes are first met."

**Response:** This language is not necessary as the requirements for extrapolation are already set forth in CGS 17b-99(d)(3).

- b. **Comment:** A commenter requested that the Department publicly release the audit tools that it uses and requests that the Department provide a minimum of 6 months of notice when it changes audit tools.

**Response:** Releasing the audit tools used by the auditors could unduly restrict the auditing process.

- c. **Comment:** A commenter requested that the Department clarify how it will determine whether the audit will consist of a review of all claims, a sample selection or a combination. Additionally, commenter believes it is essential for the Department to specify under what circumstances a combination would be used.

**Response:** The Department is unable to provide clarification in the regulations on when all claims, a sample selection or a combination would be used because there are varying circumstances which could affect this decision. The Department needs the flexibility to allow the auditors to work without unduly restricting the auditing process.

- d. **Comment:** Several commenters stated that extrapolation should only be used if the provider has broad clerical and inappropriate internal controls. Commenter states that extrapolation is not stated statutorily as a "shall" methodology.

**Response:** The Department will continue to use extrapolation to calculate overpayments or underpayments in accordance with CGS 17b-99(d)(3) and these regulations.

3) Subsection (b):

- a. **Comment:** A commenter argued that the correct experts to determine the appropriate methodology for statistical sampling of healthcare claims are statisticians, not accountants or professional auditors. Provider requests the following language: "The sampling methodology used to project overpayments must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimation methods."

**Response:** The use of statistics is part of the accounting and auditing profession, and therefore, the Department can determine the appropriate methodology for statistical sampling.

- b. **Comment:** Several commenters requested that the Department specify what standards are used when reviewing a sample selection and calculating overpayments or underpayments rather than stating it will be using methods “generally accepted by the professional auditing or accounting community.”

**Response:** The Department disagrees and believes that the regulation adequately explains the standards used when reviewing a sample selection and calculating overpayments and underpayments.

- c. **Comment:** A commenter requested that parts 7 and 8 of this subsection be deleted because it is unclear what they mean.

**Response:** The Department disagrees that these subsections should be deleted. These subsections are two of the steps that are used when selecting a sample selection.

- d. **Comment:** Several commenters requested that the Department articulate with sufficient specificity the audit sampling method it intends to rely upon to determine the sample selection. The commenters noted that a valid sample must be “random” and it must be chosen by a method that ensures that each claim in the universe to be sampled has an equal and independent chance of being chosen for the sample. Valid audit sampling methods include “simple random sampling, cluster sampling, stratified sampling, and systematic sampling.”

**Response:** The Department agrees that it will articulate the audit sampling method it uses for each audit. Please see proposed section 17b-99-3(d).

- e. **Comment:** A commenter requested that the regulations address specific auditing elements regarding sampling methodology such as confidence level for the samples, determination of an expected error rate, sampling plan, sampling techniques, how the results will be extrapolated, and guidelines about when each type of plan or technique will be used.

**Response:** The standards used for these auditing elements will be standards that are generally accepted by the professional auditing or accounting community. Any more specificity could unduly restrict the auditing process.

- f. **Comment:** Several commenters requested that the claims which will be audited be made known to the provider in advance.

**Response:** Providing the chosen samples for inspection prior to the audit occurring could unduly restrict the auditing process.

- g. **Comment:** A commenter requested that the Department specify exactly how providers are chosen to be audited and define a period of when a provider can be audited.

**Response:** The Department determines which providers to audit by considering numerous factors that include: the amount of the provider's paid claims during the audit period compared with other providers; whether the provider is among a provider type that the Department is auditing or intends to audit; whether the individual provider is newly enrolled or has been enrolled for a period of years without being subject to audit; whether the provider is among a provider type that that is newly enrolled; whether the individual provider, or the provider's provider type, has recently sought reimbursement for new types of claims; whether the provider has been the subject of audit in the past and, if so, when; whether the Department has received complaints about the individual provider; whether the Department has received complaints about provider's provider type; what guidance, suggestions, or directives has the Department received about selecting providers for audit; the availability of Department audit employees; the availability of other Department employees who may assist the audit; the availability of Department contractors who may assist the audit; and, the availability of other Department resources. The Department cannot condense its consideration of these factors and possibly other factors that may emerge into a workable regulation. In order to carry out its audit function, the Department needs flexibility to adjust to changing circumstances when selecting providers for audits. Additionally, defining a strict limitation on the frequency of audits would unduly restrict the Department's audit function.

4) Subsection (c):

- a. **Comment:** A commenter stated that the professional auditing or accounting community are not the correct fields of expertise for extrapolation methods. Provider requests the following language: "The department may calculate underpayments and overpayments by extrapolation methods that have been reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimation methods."

**Response:** The Department disagrees. The use of statistics is part of the accounting and auditing profession, and therefore, the Department can properly calculate underpayments and overpayments.

- b. **Comment:** Several commenters requested that, when extrapolating, the Department construct "confidence intervals" around the sampling results to ensure the sample results properly reflects the overall value of the universe. Commenter states that it is critical, especially where the sample is small, to use 90% or 95% Confidence Intervals to avoid unfair onerous demands of repayment.

**Response:** The standards used for extrapolation will be standards that are generally accepted by the professional auditing or accounting community. Any more specificity could unduly restrict the auditing process.

- c. **Comment:** A commenter requested that the Department provide the providers with education regarding clerical errors so that the provider can learn from these errors.

**Response:** The Department attempts to provide the necessary outreach to assist those providers who have questions or concerns regarding clerical errors.

- d. **Comment:** Several commenters claimed that CGS 17b-99 contains no authorization to extrapolate by projecting the error rate to the sampling universe.

**Response:** The Department disagrees. CGS 17b-99(d)(3) outlines when the Department can use extrapolation.

- e. **Comment:** A commenter requested that extrapolation of audit findings occur only in cases where the error or defect occurs in more than 5% of the sampled claims.

**Response:** The Department disagrees. Extrapolation of overpayments or underpayments is proper in all of the circumstances described in CGS 17b-99(d)(3).

- f. **Comment:** A commenter requested that where the audit findings involve claims where the error or defect is procedural and there is no intent to falsify or defraud and the service was medically necessary and provided to a beneficiary, that the provider be allowed to correct the defect and resubmit the claim within 60 days before a withholding occurs for those claims.

**Response:** The Department disagrees. This could unduly restrict the auditing process.

- g. **Comment:** A commenter requested a provision allowing providers to present an independent 100% audit of paid claims/payments during the audit period in lieu of the Department's sampling and extrapolation methodology.

**Response:** Providers can conduct their own audits. A provider conducted audit, however, cannot substitute for an audit conducted by the Department.

- h. **Comment:** A commenter requested that extrapolation not be used unless proper statistical methodologies are used in the calculation and that the extrapolation formula be provided to the provider as well as the statistician who did the extrapolation. The commenter also requested that any extrapolation be based on a

statistically valid random sample using stratification when appropriate and that all zero paid claims and claims with outliers be removed from the sample prior to extrapolating. Finally, the commenter requested that unless the data are normally distributed, approximately normally distributed and/or symmetrical, the median (rather than the average) amount should be used to determine the central data point per unit audited as the basis for calculating the alleged overpayment. The lower bound of the two sided 90% confidence interval should be used to calculate the alleged overpayment.

**Response:** The standards used for extrapolation will be standards that are generally accepted by the professional auditing or accounting community. Any more specificity could unduly restrict the auditing process.

5) Subsection (d):

- a. **Comment:** Several commenters requested that the Department should clearly specify, in the preliminary and final reports, the specific sampling and extrapolation methodologies used in the audit. The commenters also requested that this information be provided in advance of the audit.

**Response:** Section 17b-99-3(d) requires the Department to “state in writing in the preliminary written report and final written report the sampling methodology and extrapolation methodology for the audit and how the methodologies were applied during the audit.” Providing this information in advance of the audit, however, could unduly restrict the auditing process.

**Comments on Section 17b-99-4 (Conduct of the Audit Process):**

1) General Comments:

- a. **Comment:** A commenter suggested that a section be added about educational intervention and re-inspection or re-audit for clerical errors in providers with claims in aggregate of \$150,000 on an annual basis.

**Response:** The Department disagrees. The Department provides the necessary outreach to assist those providers who have questions or concerns regarding clerical errors. While the Department may re-audit a provider in the future, the Department does not have the necessary resources to re-audit all providers for clerical errors with claims in aggregate of \$150,000 on an annual basis.

- b. **Comment:** Several commenters requested that audits should be conducted by auditors with requisite expertise in the area being audited.

**Response:** The Department utilizes only qualified auditors.

- c. **Comment:** A commenter requested that the name and contact information of the auditor be provided up front and whether the audit will occur on-site. If the audit

is not to occur on-site, the commenter requests that information be provided regarding where and how to submit the records necessary for the audit.

**Response:** The required 30 day notice provides the necessary information to coordinate initiation of the audit process.

- d. **Comment:** A commenter requested that auditors should have no financial incentive to find errors and therefore, requests that all auditors be paid on a flat fee basis.

**Response:** Auditors are employed by the Department as salaried employees. They have no financial incentives to find errors.

2) Subsection (a):

- a. **Comment:** Several commenters requested that a clear, random process be established and specified in the regulation regarding which providers are chosen for audits and define the frequency in which providers can be chosen for audit. One suggestion was that after a provider is chosen, that provider should then not be audited again until all other providers have been audited (absent fraud).

**Response:** A random process for selecting providers for audit or a strict limitation on the frequency of audits would unduly restrict the Department's audit function. The Department determines which providers to audit by considering numerous factors that include: the amount of the provider's paid claims during the audit period compared with other providers; whether the provider is among a provider type that the Department is auditing or intends to audit; whether the individual provider is newly enrolled or has been enrolled for a period of years without being subject to audit; whether the provider is among a provider type that that is newly enrolled; whether the individual provider, or the provider's provider type, has recently sought reimbursement for new types of claims; whether the provider has been the subject of audit in the past and, if so, when; whether the Department has received complaints about the individual provider; whether the Department has received complaints about provider's provider type; what guidance, suggestions, or directives has the Department received about selecting providers for audit; the availability of Department audit employees; the availability of other Department employees who may assist the audit; the availability of Department contractors who may assist the audit; and, the availability of other Department resources. The Department cannot condense its consideration of these factors and possibly other factors that may emerge into a workable regulation. In order to carry out its audit function, the Department needs flexibility to adjust to changing circumstances when selecting providers for audits.

3) Subsection (b):

- a. **Comment:** Several commenters requested that, absent evidence of fraud, the Department limit the audit period or “look back” period to a specific number of months or years and specify what this period is in the regulation.

**Response:** This is not necessary because audits will go back no further than the document retention period specified in the provider enrollment agreement or as provided by applicable law.

- b. **Comment:** Several commenters requested that the Department choose providers to audit at random so as to avoid any appearance of selecting providers to audit based on retaliation and/or providers who are “targets.”

**Response:** The Department does not “target” providers.

4) Subsection (d):

- a. **Comment:** A commenter requested that when the Department provides a Provider with notice of an impending audit, that notice should include the time period that will be subject to audit as well as the sampling and extrapolation methodologies to be used. The commenter would also like the notice to be sent to the executive office of the provider and requests that the Department confirm receipt of the notice within 48 hours of issuance.

**Response:** The Department disagrees. To include additional information in the notice could unduly restrict the auditing process. If a provider would like to request that notice of an audit be sent to its executive office, it can do so, but to require the Department to confirm receipt of the notice within 48 hours of issuance would be an administrative burden.

5) Subsection (e):

- a. **Comment:** A commenter requested that the term “representative sample” be defined.

**Response:** The Department disagrees. A representative sample shall be selected as required by section 17b-99-3.

6) Subsection (f):

- a. **Comment:** A commenter would like the following language inserted at the end of this subsection: “Nothing herein shall abrogate any available privilege, including but not limited to, the attorney-client privilege.” Provider would like it clear that this subsection is not intended to affect or interfere with any rights or privileges the provider may hold.

**Response:** The Department does not believe this language is necessary as this subsection will not affect the rights or privileges a provider may hold.

- b. **Comment:** A commenter suggested that this section, which allows the department to “review and consider any other data that does not qualify as a document or record,” is too broad. Commenter suggests the Department develop parameters for “other data.”

**Response:** The Department disagrees that it needs to develop parameters for “other data.” It is the Department’s intention to keep this broad so that it may review any relevant information.

- c. **Comment:** A commenter requested that the Department clarify that it can only look at the claims it is reviewing rather than any documents or records.

**Response:** The Department disagrees. The Department is able to review any documents or records, not just the claims it is reviewing.

7) Subsection (g):

- a. **Comment:** A commenter would like the term “eligible client” changed to just “client” because only “client” is defined in the definitions section of 17b-99-2(4).

**Response:** The Department agrees and has changed the language accordingly.

- b. **Comment:** Several commenters requested that the determination of medical necessity in parts 3 and 4 be made by a person licensed in a clinical discipline that provides the appropriate expertise to determine medical necessity without the benefit of examining the client.

**Response:** The Department relies on qualified individuals to make medical necessity determinations.

- c. **Comment:** Several commenters requested that the Department explain what counts as “original documentation” in part 4. Does this include electronic medical records which contain scanned information?

**Response:** The definition of “documents” or “records” is defined in the definitions section of 17b-99-2(8). The Department will follow the ordinary meaning of original. The Department may, in some instances, allow electronic records which contain scanned information, but if there is any question as to the authenticity or content of the scanned document and the Department requires the original, the burden will be on the provider to produce the original documentation.

- d. **Comment:** A commenter requested that the word “original” in original documentation be deleted because many providers use facsimiles, computerized records, scanned records, and electronic records.

**Response:** The Department disagrees. The definition of “documents” or “records” is defined in the definitions section of 17b-99-2(8). The Department

will follow the ordinary meaning of original. The Department may, in some instances, allow electronic records which contain scanned information, but if there is any question as to the authenticity or content of the scanned document and the Department requires the original, the burden will be on the provider to produce the original documentation.

- e. **Comment:** A commenter suggested that in subdivision 5, the Department limit its review to just DSS statutes, regulations, policies and procedures rather than “all applicable state and federal statutes, state and federal regulations and state and federal operational policies and procedures.”

**Response:** The Department disagrees. Providers should be adhering to all applicable state and federal statutes, regulations, and operation policies and procedures, state and federal.

- f. **Comment:** A commenter suggested that in subdivision 10, that the Department add the following language to the end of the sentence “...where cost or data is required to be reported.”

**Response:** The Department does not believe this language is necessary.

- g. **Comment:** A commenter requested clarification that the list of items used by auditors in subsection (g) includes things that should not be used as the basis for an overpayment determination.

**Response:** The Department disagrees. The items listed in subsection (g) could be used as the basis for an overpayment determination. The Department needs flexibility to review anything that appears problematic.

- h. **Comment:** A commenter requested that the word “applicable” be inserted before the word “standards” in subsection (g)(7).

**Response:** The Department agrees and has changed the language accordingly.

8) Subsection (i):

- a. **Comment:** A commenter claimed that this subsection is in direct conflict with the statute. The commenter argued that the statute mandates a preliminary report “not later than 60 days after the conclusion of such audit,” but stated that the regulation requires the preliminary report to be provided not more than 60 days after the department determines, in its discretion, that the preliminary fieldwork, review and analysis on the audit has concluded.

**Response:** The Department disagrees that this subsection conflicts with the statute. This subsection explains that the audit is not concluded until the preliminary fieldwork, review and analysis is concluded. The preliminary report therefore need not be produced until 60 days after all of this work is concluded.

- b. **Comment:** A commenter requested that, absent evidence of fraud, the preliminary report be completed within a specified number of days.

**Response:** As stated in section 17b-99-4(i) of these regulations, the Department shall produce a preliminary written report not more than sixty days after the department determines, in its discretion, that the preliminary fieldwork, review and analysis on the audit has concluded. See also Conn. Gen. Stat. §17b-99(d)(5).

- c. **Comment:** A commenter requested a better process for discussion of findings.

**Response:** The Department believes that both the preliminary and final audit reports discuss the findings adequately.

- d. **Comment:** Several commenters requested that the Department hold a preliminary meeting with the provider to review its findings before a preliminary report is issued.

**Response:** The Department thinks the proposed schedule is adequate. Providers have an opportunity to meet with the Department after the preliminary report is issued, but before the final report is issued, to discuss any concerns the Provider has regarding the preliminary report.

9) Subsection (j):

- a. **Comment:** A commenter requested that the exit conference be scheduled no later than 45 days after receipt of the preliminary report.

**Response:** The Department disagrees. The Department schedules exit conferences in an expeditious manner, but situations may arise which warrant scheduling an exit conference more than 45 days after the provider receives the preliminary audit report.

10) Subsection (l):

- a. **Comment:** A commenter would like this subsection clarified by stating that "A finding of overpayment or underpayment to a provider shall not be based on extrapolation projects unless one of the statutory prerequisites set forth in 17b-99(d)(3) are first met."

**Response:** The Department does not believe this is necessary. The statutory language is assumed.

**Comments on Section 17b-99-5 (Review of Provider's Items of Aggrievement in Final Audit Report):**

1) General Comments:

- a. **Comment:** Several commenters requested that the Department specify that the review of an audit report shall be governed by the Uniform Administrative Procedures Act (UAPA).

**Response:** The Department does not believe the audit review process is governed by the Uniform Administrative Procedure Act.

- b. **Comment:** A commenter suggested that the audit appeal process have two levels: an initial request for reconsideration and a second level appeal to an external qualified third party. The commenter requests that the decision to deny a reconsideration be made by a qualified physician and the second level appeal be a third party outside of the Department.

**Response:** The Department believes that between the exit conference, the audit review and the right to appeal to Superior Court, the appeal process in the statute and regulations is adequate.

- c. **Comment:** A commenter requested the following language (from Public Act No 10-116) be included: "The designee of the commissioner who presides over the review shall be impartial and shall not be an employee of the Department of Social Services Office of Quality Assurance or an employee of an entity with whom the commissioner contracts for the purpose of conducting an audit of a service provider. Following review on all items of aggrievement, the designee of the commissioner who presides over the review shall issue a final decision."

**Response:** The Department doesn't think this is necessary. This language is already present in Conn. Gen. Stat. 17b-99(d)(8).

- d. **Comment:** A commenter requested the following language be included in the regulations: "The provider shall have the right to appeal a final decision to the Superior Court in accordance with the provisions of Chapter 54."

**Response:** The Department doesn't think this is necessary. This language is already present in Conn. Gen. Stat. 17b-99(d)(9).

2) Subsection (a):

- a. **Comment:** Several commenters argued that this subsection limits the scope of an audit review by stating that "the scope of the review shall not include or consider facts or circumstances outside the audit and the final report." The Provider argues that there is no such limitation in the statute which states that "[f]ollowing review on all items of aggrievement, the designee of the commissioner who presides over the review shall issue a final decision." Commenter would like the Department to allow any document or data that is relevant to provider compliance be considered during the review.

**Response:** The Commissioner or the Commissioner's designee will review all documents submitted which are relevant to the items of aggrievement.

- b. **Comment:** A commenter requested a provision affording providers a right to review any documents that the auditors relied on, the audit work papers and any documents related to sampling methodology prior to the deadline for deciding whether to challenge the final audit report.

**Response:** Section 17b-99-3(d) provides that both the preliminary and final reports shall include a statement of the sampling methodology and the extrapolation methodology for the audit and how the methodologies were applied during the audit. The audit work papers and documents the auditors relied upon, however, are not made available as this could unduly restrict the audit process.

3) Subsection (b):

- a. **Comment:** A commenter noted that the statute does not require more than "a detailed written description of the claim(s) of error alleged by the provider." The regulation, however, sets forth additional requirements including detailed facts that "were misapprehended or overlooked by the audit decision" or a description that identifies the state or federal statutes/regulations/policies that were misapprehended or overlooked by the audit decision. Commenter requests that this be eliminated.

**Response:** The Department has added language to the proposed regulation to clarify that the regulation is not intended to limit what the provider can submit when requesting a review of an audit. The purpose of the regulation is to add more specificity to the statute to ensure that providers are explicit about their items of aggrievement.

4) Subsection (c):

- a. **Comment:** Several commenters requested that the "designee" of the Commissioner which "presides" over the review of the final audit report be a hearing officer within the Department or an "administrative law judge" or professional with standards and a code of ethics/responsibilities – not an attorney of the Office of Legal Counsel, Regulations, and Administrative Hearings.

**Response:** The Commissioner complies with Conn. Gen. Stat. §17b-99(d)(8) when designating who will preside over the review of an audit.

- b. **Comment:** A commenter requested that the provider have the opportunity to comment on an audit review.

**Response:** There are many opportunities for providers to comment set forth in Section 17b-99-5(c).

- c. **Comment:** A commenter argued that this subsection is vague and allows the Commissioner's designee free reign to review the audit appeal in whatever fashion he or she chooses, including having ex parte communications with one party. Commenter requests that the Department, at the very least, hold an informal conference where both sides can share their position on each item of aggrievement. Commenter further suggests that after the informal process, a formal process be established for any unresolved issues to include the submission of legal briefs, written or oral testimony and/or stipulated facts.

**Response:** The Commissioner or the Commissioner's designee may hold an informal or formal conference if the Commissioner or the Commissioner's designee thinks it is necessary.

5) Subsection (d)(3):

- a. **Comment:** Several commenters requested that this be deleted or revised due to the fact that subsection (d)(3) states that the Commissioner or Commissioner's designee shall issue a final written decision that "provides recommendations to the department regarding what, if any, action should be taken including, but not limited to, changing the audit decision, not changing the audit decision, . . ." Provider argues that this is in conflict with the statute which indicates that "[f]ollowing review on all items of aggrievement, the designee of the commissioner who presides over the review shall issue a final decision."

**Response:** The Department agrees and the language in section 17b-99-5(d)(3) has been revised.

- b. **Comment:** A commenter requested that the Commissioner or his designee issue a final written decision within 45 days of the conclusion of the review.

**Response:** The Department disagrees. The Commissioner or his designee work expeditiously when audit reviews are requested. Situations may arise, however, which could prevent the Commissioner or his designee from issuing a final written decision within 45 days of the conclusion of the review.

**Comments on Section 17b-99-6 (Recovery of Overpayments):**

- 1) **Comment:** A commenter requested that this section be deleted in its entirety arguing that it is not supported by the statutory framework. Provider states that the Department has not been given the authority to recoup funds from potentially related entities, persons, or businesses and that if such authority exists, it is not found in Section 17b-99 of the CGS. Provider also argues that if such authority exists, it would require substantially greater due process than is provided for in the proposed regulation Section 17b-99-6.

**Response:** The Department disagrees. Federal law and regulations require the Department to recoup overpayments (*see* 42 C.F.R. §433.300 et. seq.; 42 U.S.C.S. § 1396a; Affordable Care Act) and Conn. Gen. Stat. § 17b-99(c) states that the

“commissioner may adopt regulations in accordance with the provisions of chapter 54 to provide for the withholding of payments currently due in order to offset money previously obtained as the result of error or fraud.” Additionally, upon enrolling as a provider, all providers sign a Provider Enrollment Agreement in which they agree to the Department’s recoupment policy.

- 2) **Comment:** Several commenters requested that, absent evidence of fraud, the Department limit the number of prior years which may be subject to recoupment of overpayments.

**Response:** Overpayments may be recouped for all prior years which are subject to audit. The time period or “look back” period for audits will go back no further than the document retention period specified in the provider enrollment agreement or as provided by applicable law.

- 3) **Comment:** Several commenters requested that if a provider seeks a review of an audit report, then this should automatically stay the recoupment of overpayments until the result of the review is released.

**Response:** The Department disagrees. As stated in Section 17b-99-6, the pendency of a review shall not *automatically* stay the recoupment. The recoupment, however, may be stayed in the discretion of the Commissioner. Nothing prohibits a provider from requesting a stay.

- 4) **Comment:** A commenter requested clarification on whether the time of indebtedness is the time of the claim or the time of the audit.

**Response:** The Affordable Care Act clearly delineates a provider’s responsibility to return overpayments. Publication of a final audit report represents the Department’s formal notification of indebtedness.

- 5) **Comment:** A commenter requested that the regulations reflect that if there is a change in ownership and the business is a different legal entity, the new owner should not be penalized for the actions of the previous owner and should not be responsible for overpayments of the previous owner.

**Response:** Whenever a provider has received overpayments, the Department may recoup the amount of such overpayments from payments to the provider regardless of any intervening change in ownership of the provider.

- 6) **Comment:** A commenter requested that if a change in ownership is pending for a provider, that the regulations should provide a process for the provider to request within a certain number of days preceding the transaction’s closing, that the Department resolve any pending audits, provide an inventory of audits that have not yet been conducted for the pre-sale period and to the extent possible, provide an estimate of potential audit liability.

**Response:** It would be administratively burdensome for the Department to resolve any pending audits, provide an inventory of audits that have not yet been conducted for the pre-sale period and provide an estimate of potential liability for providers undergoing a change in ownership. Because a change in ownership does not affect the Department's ability to recoup overpayments as discussed above in comment #5 of this section, the responsibility for a change in ownership lies with the provider, not the Department.

- 7) **Comment:** A commenter requested that recoupment of overpayments be limited to a rate no greater than 10% of current and future payments and restrict the imposition of withholding until 60 days after the issuance of the final audit report or final agency action in the case of an appeal.

**Response:** The Department disagrees. The Department recoups all overpayments made to providers. Requests for payment schedules or a stay of recoupment may be granted at the discretion of the Department.