



House of Representatives

General Assembly

File No. 523

January Session, 2015

Substitute House Bill No. 6550

House of Representatives, April 8, 2015

The Committee on Human Services reported through REP. ABERCROMBIE of the 83rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAID PROVIDER AUDITS.

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2 repealed and the following is substituted in lieu thereof (*Effective July*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, 2015*):

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 "audit look-back period"
12 means a period of time not to exceed thirty-six months from the date of
13 an audit to the date of payment of a provider's claim; "extrapolation"
14 means the determination of an unknown value by projecting the

15 results of the review of a sample to the universe from which the
16 sample was drawn; "provider" means a person, public agency, private
17 agency or proprietary agency that is licensed, certified or otherwise
18 approved by the commissioner to supply services authorized by the
19 programs set forth in said chapters; "statistically valid sampling
20 methodology" means a methodology that is validated by a statistician
21 or person with equivalent experience as having a confidence level of
22 ninety-five per cent or greater; and "universe" means a defined
23 population of claims submitted by a provider during a specific time
24 period.

25 (1) Not less than thirty days prior to the commencement of any such
26 audit, the commissioner, or any entity with which the commissioner
27 contracts to conduct an audit of a participating provider, shall provide
28 written notification of the audit and the statistically valid sampling
29 methodology to be used to such provider, unless the commissioner, or
30 any entity with which the commissioner contracts to conduct an audit
31 of a participating provider makes a good faith determination that (A)
32 the health or safety of a recipient of services is at risk; or (B) the
33 provider is engaging in vendor fraud. A copy of the regulations
34 established pursuant to subdivision (11) of this subsection shall be
35 appended to such notification.

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

45 (3) A finding of overpayment or underpayment to a provider in a
46 program operated or administered by the department pursuant to this
47 chapter or chapter 319t, 319v, 319y or 319ff, except a provider for

48 which rates are established pursuant to section 17b-340, shall not be
49 based on extrapolation of a clerical error as described in subdivision (2)
50 of this subsection unless (A) there is a determination of sustained or
51 high level of payment error involving the provider, (B) documented
52 educational intervention has failed to correct the level of payment
53 error, or (C) the [value of the claims in aggregate exceeds two hundred
54 thousand dollars on an annual basis] provider's error rate exceeds ten
55 per cent in an audit performed with a statistically valid sampling
56 methodology and the provider has a history of at least one previous
57 overpayment error identified in an audit. An overpayment assessment
58 based on extrapolation of a clerical error shall not exceed three times
59 the dollar amount of the clerical error unless there is a determination
60 of a sustained or high level of provider payment error or if a
61 documented educational intervention offered to the provider has
62 failed to correct the level of payment error. Such determination may be
63 made by means that include, but are not limited to: (i) Audit history of
64 a provider, (ii) analysis of additional samples using a statistically valid
65 sampling methodology, (iii) information from law enforcement
66 investigations, and (iv) allegations of wrongdoing by current or former
67 employees of a provider.

68 (4) A provider, in complying with the requirements of any such
69 audit, shall be allowed not less than thirty days to provide
70 documentation in connection with any discrepancy discovered and
71 brought to the attention of such provider in the course of any such
72 audit. Such documentation may include evidence that clerical errors
73 concerning payment and billing resulted from a provider's transition
74 to a new payment or billing service. The commissioner may permit a
75 provider to correct minor clerical errors prior to a final audit
76 determination. The commissioner shall not calculate an overpayment
77 based on extrapolation or attempt to recover such extrapolated
78 overpayment when the provider presents credible evidence that an
79 error by the department caused the overpayment, provided the
80 commissioner may recover the amount of the original overpayment.

81 (5) The commissioner, or any entity with which the commissioner

82 contracts, for the purpose of conducting an audit of a provider of any
83 of the programs operated or administered by the department pursuant
84 to this chapter or chapter 319t, 319v, 319y or 319ff, except a service
85 provider for which rates are established pursuant to section 17b-340,
86 shall produce a preliminary written report concerning any audit
87 conducted pursuant to this subsection, and such preliminary report
88 shall be provided to the provider that was the subject of the audit not
89 later than sixty days after the conclusion of such audit. If a preliminary
90 finding of an overpayment based on extrapolation of a clerical error
91 exceeds two hundred thousand dollars, the commissioner shall
92 schedule a conference with the provider not later than thirty days after
93 the conclusion of such audit. Not later than thirty days after such
94 conference, a provider may conduct an independent audit at the
95 provider's expense of (A) all of the claims included in the universe
96 subject to findings based on extrapolation, or (B) a second sample
97 twice the size of the original identified by the department using the
98 same statistically valid sampling methodology. The department may
99 reject any audit not based on a statistically valid sampling
100 methodology or not in compliance with state or federal law. The
101 commissioner shall amend the preliminary report in accordance with
102 any verified evidence that initial findings were incorrect.

103 (6) The commissioner, or any entity with which the commissioner
104 contracts, for the purpose of conducting an audit of a provider of any
105 of the programs operated or administered by the department pursuant
106 to this chapter or chapter 319t, 319v, 319y or 319ff, except a service
107 provider for which rates are established pursuant to section 17b-340,
108 shall, following the issuance of the preliminary report pursuant to
109 subdivision (5) of this subsection, hold an exit conference with any
110 provider that was the subject of any audit pursuant to this subsection
111 for the purpose of discussing the preliminary report. Such provider
112 may present evidence at such exit conference refuting findings in the
113 preliminary report if such provider has not already done so pursuant
114 to subdivision (5) of this subsection.

115 (7) The commissioner, or any entity with which the commissioner

116 contracts, for the purpose of conducting an audit of a service provider,
117 shall produce a final written report concerning any audit conducted
118 pursuant to this subsection. Such final written report shall be provided
119 to the provider that was the subject of the audit not later than sixty
120 days after the date of the exit conference conducted pursuant to
121 subdivision (6) of this subsection, unless the commissioner, or any
122 entity with which the commissioner contracts, for the purpose of
123 conducting an audit of a service provider, agrees to a later date or
124 there are other referrals or investigations pending concerning the
125 provider.

126 (8) Any provider aggrieved by a decision contained in a final
127 written report issued pursuant to subdivision (7) of this subsection
128 may, not later than thirty days after the receipt of the final report,
129 request, in writing, a review on all items of aggrievement. Such request
130 shall contain a detailed written description of each specific item of
131 aggrievement. The designee of the commissioner who presides over
132 the review shall be impartial and shall not be an employee of the
133 Department of Social Services Office of Quality Assurance or an
134 employee of an entity with which the commissioner contracts for the
135 purpose of conducting an audit of a service provider. Following
136 review on all items of aggrievement, the designee of the commissioner
137 who presides over the review shall issue a final decision.

138 (9) A provider may appeal a final decision issued pursuant to
139 subdivision (8) of this subsection [to the Superior Court] in accordance
140 with the provisions of chapter 54. In any appeal involving an
141 extrapolated clerical error, the department shall not subject the
142 provider to an overpayment assessment or recoupment order that
143 exceeds the amount of the original error until all administrative
144 appeals have been exhausted pursuant to chapter 54.

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

148 (11) The commissioner shall adopt regulations, in accordance with

149 the provisions of chapter 54, to carry out the provisions of this
150 subsection. [and to ensure the fairness of the audit process, including,
151 but not limited to, the sampling methodologies associated with the
152 process.] The regulations shall include but not be limited to: (A) A
153 listing of the statistically valid sampling methodologies to be used, (B)
154 the minimum qualifications of the statistician or person with
155 equivalent experience who shall validate such methodologies, (C)
156 limitations on audits to cover only paid claims and, whenever possible,
157 the isolation of unique or rare claims from others in any sample subject
158 to extrapolation, (D) the application of a median rather than an
159 average in any extrapolation involving claims with multiple services,
160 (E) an audit look-back period in accordance with this subsection, and
161 (F) administrative appeal procedures set forth in a manner that is
162 consistent with the provisions of chapter 54.

163 (12) The commissioner shall provide free training to providers on
164 how to enter claims to avoid clerical errors and shall post information
165 on the department's Internet web site concerning the auditing process
166 and methods to avoid clerical errors. Not later than February 1, 2015,
167 the commissioner shall establish and publish on the department's
168 Internet web site audit protocols to assist the Medicaid provider
169 community in developing programs to improve compliance with
170 Medicaid requirements under state and federal laws and regulations,
171 provided audit protocols may not be relied upon to create a
172 substantive or procedural right or benefit enforceable at law or in
173 equity by any person, including a corporation. The commissioner shall
174 establish audit protocols for specific providers or categories of service,
175 including, but not limited to: (A) Licensed home health agencies, (B)
176 drug and alcohol treatment centers, (C) durable medical equipment,
177 (D) hospital outpatient services, (E) physician and nursing services, (F)
178 dental services, (G) behavioral health services, (H) pharmaceutical
179 services, and (I) emergency and nonemergency medical transportation
180 services. The commissioner shall ensure that the Department of Social
181 Services, or any entity with which the commissioner contracts to
182 conduct an audit pursuant to this subsection, has on staff or consults
183 with, as needed, a medical or dental professional who is experienced in

184 the treatment, billing and coding procedures used by the provider
185 being audited.

186 Sec. 2. Section 17b-99a of the general statutes is repealed and the
187 following is substituted in lieu thereof (*Effective July 1, 2015*):

188 (a) (1) For purposes of this section, (A) "audit look-back period"
189 means a period of time not to exceed thirty-six months from the date of
190 an audit to the date of payment of a provider's claim; (B)
191 "extrapolation" means the determination of an unknown value by
192 projecting the results of the review of a sample to the universe from
193 which the sample was drawn, [(B)] (C) "facility" means any facility
194 described in this subsection and for which rates are established
195 pursuant to section 17b-340, (D) "statistically valid sampling
196 methodology" means a methodology that is validated by a statistician
197 or person with equivalent experience as having a confidence level of
198 ninety-five per cent or greater, and [(C)] (E) "universe" means a
199 defined population of claims submitted by a facility during a specific
200 time period.

201 (2) The Commissioner of Social Services shall conduct any audit of a
202 licensed chronic and convalescent nursing home, chronic disease
203 hospital associated with a chronic and convalescent nursing home, a
204 rest home with nursing supervision, a licensed residential care home,
205 as defined in section 19a-490, and a residential facility for persons with
206 intellectual disability which is licensed pursuant to section 17a-227 and
207 certified to participate in the Medicaid program as an intermediate
208 care facility for individuals with intellectual disabilities in accordance
209 with the provisions of this section.

210 (b) Not less than thirty days prior to the commencement of any such
211 audit, the commissioner shall provide written notification of the audit
212 to such facility and the statistically valid sampling methodology to be
213 used, unless the commissioner makes a good-faith determination that
214 (1) the health or safety of a recipient of services is at risk; or (2) the
215 facility is engaging in vendor fraud under sections 53a-290 to 53a-296,
216 inclusive.

217 (c) Any clerical error, including, but not limited to, recordkeeping,
218 typographical, scrivener's or computer error, discovered in a record or
219 document produced for any such audit, shall not of itself constitute a
220 wilful violation of the rules of a medical assistance program
221 administered by the Department of Social Services unless proof of
222 intent to commit fraud or otherwise violate program rules is
223 established. In determining which facilities shall be subject to audits,
224 the Commissioner of Social Services [may] shall give consideration to
225 the history of a facility's compliance in addition to other criteria used
226 to select a facility for an audit.

227 (d) A finding of overpayment or underpayment to such facility shall
228 not be based on extrapolation of a clerical error as described in
229 subsection (c) of this section unless (1) there is a determination of
230 sustained or high level of payment error involving the facility, (2)
231 documented educational intervention has failed to correct the level of
232 payment error, or (3) [the value of the claims in aggregate exceeds two
233 hundred thousand dollars on an annual basis] the facility's error rate
234 exceeds ten per cent in an audit performed with a statistically valid
235 sampling methodology and the facility has a history of at least one
236 previous overpayment error identified in an audit. An overpayment
237 assessment based on extrapolation of a clerical error shall not exceed
238 three times the dollar amount of the clerical error unless there is a
239 determination of a sustained or high level of payment error or if a
240 documented educational intervention offered to the facility has failed
241 to correct the level of payment error. Such determination may be made
242 by means that include, but are not limited to: (A) Audit history of a
243 facility, (B) analysis of additional samples using a statistically valid
244 sampling methodology, (C) information from law enforcement
245 investigations, and (D) allegations of wrongdoing by current or former
246 employees of a facility.

247 (e) A facility, in complying with the requirements of any such audit,
248 shall be allowed not less than thirty days to provide documentation in
249 connection with any discrepancy discovered and brought to the
250 attention of such facility in the course of any such audit. Such

251 documentation may include evidence that clerical errors concerning
252 payment and billing resulted from a facility's transition to a new
253 payment or billing service. The commissioner may permit a facility to
254 correct minor clerical errors prior to a final audit determination. The
255 commissioner shall not calculate an overpayment based on
256 extrapolation or attempt to recover such extrapolated overpayment
257 when the facility presents credible evidence that an error by the
258 department caused the overpayment, provided the commissioner may
259 recover the amount of the original overpayment.

260 (f) The commissioner shall produce a preliminary written report
261 concerning any audit conducted pursuant to this section and such
262 preliminary report shall be provided to the facility that was the subject
263 of the audit not later than sixty days after the conclusion of such audit.
264 If a preliminary finding of an overpayment based on extrapolation of a
265 clerical error exceeds two hundred thousand dollars, the commissioner
266 shall schedule a conference with the facility's representatives not later
267 than thirty days after the conclusion of such audit. Not later than thirty
268 days after such conference, a facility may conduct an independent
269 audit at the facility's expense of (1) all of the claims included in the
270 universe subject to findings based on extrapolation, or (2) a second
271 sample twice the size of the original identified by the department
272 using the same statistically valid sampling methodology. The
273 department may reject any audit not based on a statistically valid
274 sampling methodology or not in compliance with state or federal law.
275 The commissioner shall amend the preliminary report in accordance
276 with any verified evidence that initial findings were incorrect.

277 (g) The commissioner shall, following the issuance of the
278 preliminary report pursuant to subsection (f) of this section, hold an
279 exit conference with any facility that was the subject of any audit
280 pursuant to this subsection for the purpose of discussing the
281 preliminary report. Such facility may present evidence at such exit
282 conference refuting findings in the preliminary report if such facility
283 has not already done so pursuant to subsection (f) of this section.

284 (h) The commissioner shall produce a final written report
285 concerning any audit conducted pursuant to this subsection. Such final
286 written report shall be provided to the facility that was the subject of
287 the audit not later than sixty days after the date of the exit conference
288 conducted pursuant to subsection (g) of this section, unless the
289 commissioner and the facility agree to a later date or there are other
290 referrals or investigations pending concerning the facility.

291 (i) Any facility aggrieved by a final report issued pursuant to
292 subsection (h) of this section may request a rehearing. A rehearing
293 shall be held by the commissioner or the commissioner's designee,
294 provided a detailed written description of all items of aggrievement in
295 the final report is filed by the facility not later than ninety days
296 following the date of written notice of the commissioner's decision.
297 The rehearing shall be held not later than thirty days following the
298 date of filing of the detailed written description of each specific item of
299 aggrievement. The commissioner shall issue a final decision not later
300 than sixty days following the close of evidence or the date on which
301 final briefs are filed, whichever occurs later. Any items not resolved at
302 such rehearing to the satisfaction of the facility or the commissioner
303 shall be submitted to binding arbitration by an arbitration board
304 consisting of one member appointed by the facility, one member
305 appointed by the commissioner and one member appointed by the
306 Chief Court Administrator from among the retired judges of the
307 Superior Court, which retired judge shall be compensated for his
308 services on such board in the same manner as a state referee is
309 compensated for his services under section 52-434. The proceedings of
310 the arbitration board and any decisions rendered by such board shall
311 be conducted in accordance with the provisions of the Social Security
312 Act, 42 USC 1396, as amended from time to time, and chapter 54. In
313 any case involving an extrapolated clerical error, the department shall
314 not subject the facility to an overpayment assessment or recoupment
315 order that exceeds the amount of the original error until the facility
316 exhausts any rights pursuant to this section.

317 (j) The submission of any false or misleading fiscal information or

318 data to the commissioner shall be grounds for suspension of payments
319 by the state under sections 17b-239 to 17b-246, inclusive, and sections
320 17b-340 and 17b-343, in accordance with regulations adopted by the
321 commissioner. In addition, any person, including any corporation,
322 who knowingly makes or causes to be made any false or misleading
323 statement or who knowingly submits false or misleading fiscal
324 information or data on the forms approved by the commissioner shall
325 be guilty of a class D felony.

326 (k) The commissioner, or any agent authorized by the commissioner
327 to conduct any inquiry, investigation or hearing under the provisions
328 of this section, shall have power to administer oaths and take
329 testimony under oath relative to the matter of inquiry or investigation.
330 At any hearing ordered by the commissioner, the commissioner or
331 such agent having authority by law to issue such process may
332 subpoena witnesses and require the production of records, papers and
333 documents pertinent to such inquiry. If any person disobeys such
334 process or, having appeared in obedience thereto, refuses to answer
335 any pertinent question put to the person by the commissioner or the
336 commissioner's authorized agent or to produce any records and papers
337 pursuant thereto, the commissioner or the commissioner's agent may
338 apply to the superior court for the judicial district of Hartford or for
339 the judicial district wherein the person resides or wherein the business
340 has been conducted, or to any judge of such court if the same is not in
341 session, setting forth such disobedience to process or refusal to answer,
342 and such court or judge shall cite such person to appear before such
343 court or judge to answer such question or to produce such records and
344 papers.

345 (l) The commissioner shall adopt regulations, in accordance with the
346 provisions of chapter 54, to carry out the provisions of this section,
347 [and to ensure the fairness of the audit process, including, but not
348 limited to, the sampling methodologies associated with the process.]
349 The regulations shall include, but not be limited to: (1) A listing of the
350 statistically valid sampling methodologies to be used, (2) the minimum
351 qualifications of the statistician or person with equivalent experience

352 who shall validate such methodologies, (3) limitations on audits to
353 cover only paid claims and, whenever possible, the isolation of unique
354 or rare claims from others in any sample subject to extrapolation, (4)
355 the application of a median rather than an average in any extrapolation
356 involving claims with multiple services, (5) an audit look-back period
357 in accordance with this section, and (6) administrative appeal
358 procedures set forth in a manner that is consistent with the provisions
359 of this section. The commissioner shall provide free training to
360 facilities on the preparation of cost reports to avoid clerical errors and
361 shall post information on the department's Internet web site
362 concerning the auditing process and methods to avoid clerical errors.
363 Not later than April 1, 2015, the commissioner shall establish audit
364 protocols to assist facilities subject to audit pursuant to this section in
365 developing programs to improve compliance with Medicaid
366 requirements under state and federal laws and regulations, provided
367 audit protocols may not be relied upon to create a substantive or
368 procedural right or benefit enforceable at law or in equity by any
369 person, including a corporation. The commissioner shall establish and
370 publish on the department's Internet web site audit protocols for: [(1)]
371 (A) Licensed chronic and convalescent nursing homes, [(2)] (B) chronic
372 disease hospitals associated with chronic and convalescent nursing
373 homes, [(3)] (C) rest homes with nursing supervision, [(4)] (D) licensed
374 residential care homes, as defined in section 19a-490, and [(5)] (E)
375 residential facilities for persons with intellectual disabilities that are
376 licensed pursuant to section 17a-227 and certified to participate in the
377 Medicaid program as intermediate care facilities for individuals with
378 intellectual disabilities. The commissioner shall ensure that the
379 Department of Social Services, or any entity with which the
380 commissioner contracts to conduct an audit pursuant to this section,
381 has on staff or consults with, as needed, licensed health professionals
382 with experience in treatment, billing and coding procedures used by
383 the facilities being audited pursuant to this section.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>July 1, 2015</i>	17b-99(d)
Sec. 2	<i>July 1, 2015</i>	17b-99a

HS *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 16 \$	FY 17 \$
Social Services, Dept.	GF - See Below	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill could result in 1) a revenue loss associated with limiting when the Department of Social Services (DSS) can use extrapolation in claims involving clerical errors, and 2) a revenue gain associated with removing restrictions on the use of extrapolation of audited claims that do not involve clerical errors.

It cannot be known in advance to what extent the changes in the bill may impact current auditing results. For purposes of context, DSS identified over \$43 million in gross recoveries (a cost avoidance of about \$21 million) due to audits for FY 15 as of March 2015. 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 Out Years

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

OLR Bill Analysis**sHB 6550*****AN ACT CONCERNING MEDICAID PROVIDER AUDITS.*****SUMMARY:**

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

Principally, the bill:

1. eliminates restrictions on when DSS can make findings of over- or under-payment using extrapolation of audited claims that do not involve clerical errors (extrapolation is a statistical method to project overall results based on a sampling of claims);
2. limits the (a) circumstances in which DSS may make these findings using extrapolation in claims involving clerical errors and (b) value of an assessment calculated through extrapolation use in certain circumstances;
3. prohibits DSS from extrapolating an overpayment or attempting to recover an extrapolated overpayment beyond the payment's original dollar amount if the provider presents credible evidence that a DSS error caused the overpayment;
4. requires, instead of permits, DSS to consider a provider's or facility's compliance history when determining whether to subject the provider or facility to an audit;
5. establishes certain procedures DSS must follow if a preliminary finding of overpayment based on extrapolation exceeds \$200,000;
6. prohibits DSS from subjecting a provider or facility to an

overpayment or recoupment order, based on an audit that extrapolated a clerical error, that exceeds the amount of the original error until all the administrative appeals available are exhausted; and

7. requires DSS to (a) give providers and facilities that are going to be audited written notification of the statistically valid sampling methodology (SVSM) the auditors will use and (b) adopt certain regulations pertaining to audit practices.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2015

EXTRAPOLATION

Use in Audits

By law, extrapolation means the determination of an unknown value by projecting the results of a review of a sample of claims to the entire population of claims from which the sample was drawn.

Current law prohibits DSS from finding that an overpayment or underpayment was made to a provider or facility based on extrapolated projections if (1) the provider or facility has a sustained or high level of payment error, (2) documented educational intervention has failed to correct the error levels, or (3) the aggregate claims' value exceeds \$200,000 on an annual basis.

The bill instead prohibits DSS from making such findings based on extrapolation of a clerical error (e.g., recordkeeping, typographical, scrivener's, or computer error) unless (1) the provider or facility has a sustained or high level of payment error, (2) documented educational intervention has failed to correct the error levels or (3) the provider's or facility's error rates exceed 10% in an audit performed with an SVSM and the provider or facility had at least one previous overpayment error identified in an audit.

Under the bill, SVSM is a methodology validated by a statistician or

person with equivalent experience as having a 95% or greater confidence level.

Assessment Based on Extrapolated Claims

The bill also limits the assessment imposed for an overpayment calculated through extrapolation of a clerical error to three times the error's dollar amount unless (1) there is a determination of sustained or high level payment error or (2) documented educational intervention has failed to correct the error. The determination may be made based on (1) the provider's or facility's audit history, (2) additional sample analysis using SVSM, (3) information from law enforcement investigations, (4) allegations of wrongdoing by current or former employees, or (5) other means.

By law, a provider must be allowed at least 30 days to provide documentation in connection with any discrepancy found in an audit and brought to the provider's attention. The bill specifies that the documentation may include evidence that clerical errors concerning payment and billing resulted from a provider's transition to a new payment or billing service.

The bill allows DSS to permit a provider to correct minor clerical errors before a final audit determination. It prohibits DSS from extrapolating an overpayment or attempting to recover an extrapolated overpayment beyond the payment's original dollar amount if the provider presents credible evidence that a DSS error caused the overpayment, but it allows DSS to still recover the original overpayment amount.

Overpayments Exceeding \$200,000

The law requires DSS to (1) provide a preliminary report to the audited provider or facility within 60 days of the audit's conclusion and (2) schedule an exit conference with the provider or facility after the preliminary report is issued. Under the bill, if a preliminary finding of overpayment based on extrapolation exceeds \$200,000, DSS must schedule a conference with the provider or the facility's

representatives within 30 days of the audit's conclusion. Providers and facilities may, at their own expense, conduct a second audit within 30 days after the conference of (1) all the claims included in the claim population subject to extrapolated findings or (2) a second sample twice the size of the original identified by DSS using the same SVSM. DSS may reject any audit not based on SVSM or not in compliance with state or federal law. If the second audit proves the initial findings were incorrect, DSS must amend the preliminary report to reflect the correction.

Appeals

By law, (1) a provider aggrieved by a decision contained in the final audit report can request a review, which is presided over by an impartial DSS designee, and (2) any facility aggrieved by a decision may request a rehearing. The provider may appeal the designee's final decision in accordance with the Uniform Administrative Procedures Act (UAPA), and a facility may appeal the rehearing decision to an arbitration board.

Under the bill, if a provider or facility appeals a final decision involving an extrapolated clerical error, DSS cannot subject the provider or facility to an overpayment or recoupment order that exceeds the amount of the original error until all the administrative appeals available are exhausted.

Provider Notice

Current law requires DSS, within 30 days of auditing a provider or facility, to give the provider or facility written notice of the audit unless DSS makes a good faith determination that (1) a recipient's health or safety is at risk or (2) the provider or facility is engaging in vendor fraud. The bill requires DSS to also provide notice of the SVSM to be used in the audit.

REGULATIONS

By law, DSS must adopt regulations in accordance with the UAPA to carry out the law's provider and facility audit provisions. Currently,

the regulations must also be adopted to ensure fairness of the audit process and include the associated sampling methodologies. The bill instead requires DSS to adopt regulations that include:

1. a list of SVSMs to be used;
2. the minimum qualifications of the statistician or person with equivalent experience who will validate the methodologies;
3. limitations on audits to cover only paid claims and, whenever possible, the isolation of unique or rare claims from others in any sample that may be extrapolated;
4. the use of a median rather than an average in any extrapolation involving claims with multiple services;
5. an audit look-back period of no more than 36 months from the date of the audit to the date of the provider's or facility's claim payment; and
6. processes consistent with the laws for provider and facility administrative appeals.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 18 Nay 0