CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
HUMAN SERVICES COMMITTEE
Wednesday, February 11, 2015

Proposed HB 6550, An Act Concerning Medicaid Provider Audits

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **Proposed HB 6550, An Act Concerning Medicaid Provider Audits**. CHA supports the bill.

Connecticut hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay.

Before commenting on the bill, it's important to point out that this is a time of unprecedented change in healthcare, and Connecticut hospitals are leading the charge to transform the way care is provided. They are focused on providing safe, accessible, equitable, affordable, patient-centered care for all, and they are finding innovative solutions to integrate and coordinate care to better serve their patients and communities.

Over the last year, CHA has been working with many healthcare provider associations representing physicians, dentists, nursing homes, home health, adult day centers, retail pharmacies, clinical laboratories, homemaker companion agencies, and community providers on issues relating to the Department of Social Services' (DSS) audits. It is important to note at the outset that CHA supports the Department's efforts to monitor and audit reimbursement under Medicaid and other state programs and to uncover and address fraud. Fraud, waste, and abuse drive up costs for everyone in the healthcare system, in addition to hurting the long-term solvency of these important healthcare programs upon which thousands of Connecticut residents depend. When unscrupulous parties steal from Medicaid, there is less money available to pay for the care patients need. This is why we support HB 6550, which maintains the audit program but adds fairness to the process.

Specifically, HB 6550 seeks to establish: (1) clear parameters governing the use of extrapolation in Medicaid provider audits, (2) specific minimum standards for statistical sampling, including a minimum error rate and types of statistical sampling that may be used, (3) acceptable methods by which providers may challenge extrapolated findings of overpayment, and (4) requirements concerning transparency, outreach, and education by the Department of Social Services to reduce provider errors.

CHA, along with many of the state's other provider associations, has worked collaboratively to develop detailed proposals, which are attached to this testimony, to achieve transparency in audit practices, clarity for Medicaid providers, and fairness of the audit process.

Hospital and other providers want to comply with the existing varied, detailed, and often complicated rules governing the Medicaid process. Passage of HB 6550 will assist in providing the clarity and fairness needed.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

Summary of Proposed Changes
Department of Social Services Provider Audit Process

A coalition of care providers met in 2014 to identify key measures necessary to achieve transparency in audit practices, clarity for Medicaid providers, and fairness of the audit process. The coalition includes the Connecticut Hospital Association, the Connecticut Association for Healthcare at Home, the Connecticut Association for Health Care Facilities, the Connecticut State Medical Society, LeadingAge Connecticut, the Connecticut State Dental Association, the Connecticut Community Providers Association, the Connecticut Pharmacist Association, the CT Homemaker & Companion Association, Companions and Homemakers, CVS Health, Quest Diagnostics, the Northeast Pharmacy Service Corp., and the Connecticut Association of Community Pharmacies, Inc. The coalition's recommendations are described below.

Extrapolation

Extrapolation is a statistical technique for inferring what occurred outside the range of what was actually measured, and should not be used in the following circumstances:

1. **Across Disparate Services**: Do not extrapolate across disparate services, apply only to like claims.
2. **ED vs. Non-ED Claims**: Claims related to emergency medical care should not be extrapolated to claims not related to emergency care.
3. **Observation Care**: Claims for any appropriate medical care for anyone in observation status after 23 hours.
4. **Clerical Errors**: Circumstances involving a clerical error, especially when there was no financial impact resulting from the error.
5. **Unintentional Overlap in Services**: When two unrelated providers submit claims for serving Medicaid clients during the same time period, caused by circumstances beyond their control.
6. **Transition to New Billing Procedures**: When payment or billing errors result from a transition to a new billing procedure.
7. **Prior to Policy Effective Date**: When claims were submitted prior to the issuance of the specific audit and/or reimbursement policy that is the subject of the audit.
8. **No Notice of Service Plan Amendment**: When the provider demonstrates that it was not made aware of a plan amendment prior to providing the service.
9. **Unique or Rarely Used Claims**: Unique claims should be dealt with individually.
10. **Outlier Claims**: Outlier claims should be dealt with individually.

Sampling Methodology

Extrapolation projections must be based on a statistically valid random sample, as reviewed by a statistician or by a person with equivalent expertise in probability sampling and estimation methods.

1. **Early Disclosure of Sampling Methodology**: The methodology should be disclosed at the outset of the audit.
2. **Sample Stratification**: Claims should only be pulled that are specific to the procedure or service identified by the CPT code.
3. **Use of Median vs. Average**: The median should be applied in cases in which claims with multiple services are being extrapolated to reduce the overweighting of multiple claims.
4. **Paid Claims Only**: The universe of claims to be sampled cannot exclude claims for which no payment was issued.

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Department of Social Services Provider Audit Process

Fairness of the Audit Process

These measures should be implemented to ensure the fairness of the audit process:

1. **Compliance with Federal and State Rules**: A provider should be permitted to raise, at any time, including as an item of aggrievement, that its compliance with a state or federal law or regulation explains or negates a negative finding in an audit.
2. **Additional Information to be Provided by the Auditor**: Auditors should provide the following information regarding audit activities:
    a. At the commencement of the audit:
        i. The name and contact information of the specific auditor(s);
        ii. The audit location – either on site or through record submission;
        iii. The manner by which information shall be submitted; and
        iv. The sampling methodology to be employed in the audit.
    b. When extrapolation is used, the formula and data/claims used in the sampling shall be provided to the provider and disclosed in the audit report.
3. **Auditor Qualifications:** Auditors must undergo training and possess certain qualifications:
    a. Auditors must have coding experience, including but not limited to applicable ICD, CPT, and HCPCS codes.
    b. Decisions regarding medical necessity must be made by a professional licensed in the same clinical discipline.
    c. Auditors must have general knowledge of the particular provider services under audit and the Medicaid program they are auditing.
    d. Sampling methodology must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimate methods.
4. **Composition of the Audit Team:** The team must include qualified individuals, such as medical or dental professionals experienced in treatment, billing, and coding procedures.
5. **Appeals:** The audit appeals process should include at least 2 levels: (1) the initial request for reconsideration and (2) a second level appeal to an external party.
6. **No Recoupment While Appeal is Pending**: A provider will not be subject to alleged overpayment, re-payments, or recoupment while an appeal is pending.
7. **Look-Back Period:** Expressly limit the "look-back" period for audits to claims that are not more than two years from the date the claim was filed.
8. **Timing and Frequency of Audits:** Achieve greater transparency in the scheduling and frequency of audits. The Department should complete the audit report in a timely fashion.
9. **Conference before Issuing a Preliminary Written Report**: When an extrapolated figure exceeds $200,000, a conference must be held before the auditor issues a preliminary written report.
10. **Comparison of Preliminary Audit Findings vs. Final Written Report**: Publish an annual report comparing de-identified audit findings included in preliminary written reports against those included in final audit reports.