CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME™

TESTIMONY

Provided by Deborah R. Hoyt, President and CEO
The Connecticut Association for Healthcare at Home

Human Services Committee Public Hearing

February 11, 2015

IN SUPPORT: HB 6550 AN ACT CONCERNING MEDICAID PROVIDER AUDITS

Good evening Senator Moore, Representative Abercrombie and members of the Human Committee. My name is Deborah Hoyt, President and CEO of the Connecticut Association for Healthcare at Home.

The Association represents 62 licensed home health and hospice agencies that foster cost-effective, person-centered healthcare for the Connecticut's Medicaid population in the setting they prefer most – their own homes.

Connecticut home health agencies are major employers with a growing workforce and an "on-the-ground army" of approximately 17,500 employees. We ensure that chronic conditions of the Medicaid frail elderly, disabled, and homebound are managed and their healthcare is coordinated across the provider continuum.

The Association and our member agencies collaborate closely with the Department of Social Services (DSS) and are an integral part of achieving the State's Long Term Care goals of Aging in Place and rebalancing through the Money Follows the Person (MFP) Program.

We appreciate your interest in hearing the provider perspective and raising **HB 6550 AN ACT CONCERNING MEDICAID PROVIDER AUDITS.**

Medicaid home health care provided by the state's licensed agencies ***is*** the cost effective means of delivering care and achieving significant cost savings to the state's annual budget.

Based on the CT Home Care Program for Elders Annual Report to the Legislature for State Fiscal years 2009-2013:

- **DSS reported $533.5 million in Medicaid savings** directly attributable to the utilization of home and community based services. Additional savings are being achieved by behavioral home health services managed under Value Options.

- **Home care agencies have been implementing additional cost cutting measures and belt tightening to further decrease DSS monthly home health expenditures.** Over the 5-year period, the monthly DSS expenditure for home health services in the CT Home Care Program for Elders decreased by over 30%.

- The value and return on investment of Connecticut's licensed home health agencies to DSS, the Medicaid program, and to the State budget is unparalleled. **We're on track to save DSS more than a $100 million again this year** under the Home and Community Based Services Waiver program alone.

However, these significant savings to the state Medicaid program and the overall state budget are at significant risk. The underfunding, lack of reinvestment into this safety net provider sector, and inadequate reimbursement is well known. The additional pressures of the audit process and take-backs are jeopardizing the viability of several of our long-standing reputable agencies. Four home health agencies have closed in the past 3 years, as their mission to provide care to Medicaid clients was unsustainable under the current rate structure, compounded by audits.

Connecticut's licensed home health agencies work diligently to fully comply with Medicaid provider regulations. We agree that a fair and effective audit process is important to the integrity of the Medicaid program.

We have met with DSS and the audit team to share our concerns and appreciate their efforts in increasing provider education and audit process transparency through the creation of protocols for home health and home care providers. We submitted input to DSS on January 30, 2015 for the protocols, however DSS had already posted their version online to comply with their mandated posting date of Feb. 1, 2015. We have been told by DSS that they are willing to meet to discuss the incorporation of our comments.

The CT Association for Healthcare at Home participated in the drafting of a comprehensive list of provider audit concerns with the Association Collaborative. Home health's primary concerns included: the audit interpretation of "clerical errors", extrapolation, fair and statistically valid sampling, and the need for exit interviews to avoid unreasonable initial finding letters.

Thank you for the opportunity to testify and express our perspective. I am available to answer any questions that you may have or meet to provide additional detail.

The collaborative document is attached to provide additional detail.

Prepared by the Audit Regulation Provider Coalition
January 23, 2015

The following recommendations are intended to achieve greater transparency for those individuals conducting Medicaid audits, greater clarity for those Medicaid providers that are subject to audit, and fairness of the audit process.

AUDIT PRACTICES AND MEDICAID GOALS: Medicaid coverage facilitates access to care for people with low incomes, and is a core source of financing for safety-net hospitals, health centers, nursing homes and community-based long-term care that serve low-income communities, including many of the uninsured. As such, the audit process should ensure that healthcare providers are paid for medically appropriate and necessary care to beneficiaries.

EXTRAPOLATION: Extrapolation is a means of determining an unknown value by projecting the results of a sample to the larger universe from which the sample was drawn. It is an educated guess, a statistical technique for inferring what occurred outside the range of what was actually measured. The regulations must specify that 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 met. These prerequisites include (A) a determination of sustained or high level of payment error involving the provider, (B) a finding that documented educational intervention has failed to correct the level of payment error, or (C) the value of the claims in the aggregate exceeds two hundred thousand dollars on an annual basis.

The guiding statute and regulations should provide that extrapolation projection techniques should not be used in the following circumstances:

- Disparate Services: Extrapolation should not be conducted across disparate services. They should only be applied to "like claims."

- Emergency Department Claims: Claims related to a level of care provided in a hospital emergency department should not be extrapolated to claims not related to the provision of emergency medical care.

- Observation Care: DSS's current practice is to deny payment for claims for any appropriate medical care for anyone in observation status after 23 hours. This policy must be modified to provide payment to hospitals for medically appropriate care made for individuals in observation status beyond 23 hours. These claims should not be subject to extrapolation.

- Clerical Errors: Extrapolation should not be applied in circumstances involving clerical errors. This is especially relevant when evidence supports that the services subject to the claim were performed as agreed to, and there was no financial impact resulting from the error. Clerical errors, such as missing checkmarks, should not be used to determine whether services were performed as agreed to, if other evidence may be submitted to support that those services were performed. *(See Section below for additional comments and recommendations on the definition of the term "Clerical error.")*

- Unintentional Overlap In Services: Extrapolation should not be applied when occasional overlaps of time occur between two unrelated service providers that submit claims for serving Medicaid clients during the same time period, caused by circumstances beyond the providers' control, (e.g., client arriving home late on the adult day center bus while a companion was waiting at the house for the client's arrival.)

- Transition to New Billing Procedures: Extrapolation should not be conducted utilizing payment or billing errors that were the result of a transition to new billing procedures, (e.g., transition to new DSS Connecticut Home Care Program in 2014-15).

- Align Sample Scope to Policy Effective Date: Extrapolation should not be conducted over a sample of claims that were submitted prior to the issuance of the specific audit and/or reimbursement policy that is the subject of the audit.

- Notice of Service Plan Amendment: Extrapolation should not be conducted utilizing an underpayment or overpayment of a claim that was found to be non-compliant with a client's service plan, as such plan has been amended, if the provider can demonstrate that it was not made aware of the plan amendment prior to providing the service.

- Procedures/Codes Subject to Extrapolation: After reviewing a sampling of claims, if there is found to be a claim that is unique by services or rarely used, then DSS shall not use those claims to extrapolate over the entire population of claims, but just to that service line or on an individual basis.

- Zero-Paid Claims: All zero paid claims and claims with outliers must be removed from the sample prior to extrapolating any payment due. If the auditor believes that any claims with outliers have been overpaid, those claims should be dealt with individually and outside of the extrapolation process.

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.

- Early Disclosure of Sampling Methodology: The sampling methodology used by an auditor should be disclosed to the provider at the outset of the audit.

- Sample Stratification: The Department shall be authorized to stratify samples where appropriate – apportioning items included in a sample into different sections, based on the type of service provided. Claims should only be pulled that are specific to the procedure or service at hand as identified by the CPT code. For example, a sample universe that includes claims coded as office visits should not include a claim that has both an office visit code and a preventive medicine visit code.

- Use of Median vs. Average: Regulations should specify that when using extrapolation projection techniques, 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, unless the data are normally distributed, approximately normally distributed and/or symmetrical. If sample stratification is not adopted as described above, in cases where there are claims with multiple services being extrapolated, then the median average should be used, in order to reduce the overweighting of those multiple service claims.

- Paid Claims Only: The universe of claims to be sampled cannot exclude claims for which no payment issued. Sampling methodology based upon paid claims only is not a random sample.

CLERICAL ERRORS – NEED FOR CONSISTENT DEFINITIONS: Prior departmental drafts of proposed regulations have defined the term "clerical error" as "a discrete, isolated, recordkeeping, typographical, scrivener or computer error that is due to unwitting mistake or inadvertence by the provider and not an indication of the exercise of intention by the provider." This proposed definition is inconsistent with the statutory language, which includes the phrase "any clerical error." See Conn. Gen. Stat. §17b-99(d)(3). The text of any proposed regulation must not improperly limit the protection provided for by statute; that is, protecting only discrete or isolated events or record entries rather than "any clerical error" as provided under Section 17b-99(d)(3) of the General Statutes.

RECOVERY OF OVERPAYMENTS FROM RELATED ENTITIES: Connecticut law does not confer upon the Department the authority to recoup funds from potentially related entities, persons, or businesses. Prior versions of draft regulations have provided for such authority, which is not supported by the statutory framework. We note that any

proposal to establish such authority would require a statutory change, and must include substantially greater due process than has been provided for in previous draft regulations provided by the Department.

FAIRNESS OF THE AUDIT PROCESS: In an effort to ensure fairness of the audit process, we ask that the following language be added to the regulation:

- Compliance with Federal and State Rules: An auditor should be required to consider a provider's explanation of compliance with laws and/or regulations when determining overpayments or underpayments. 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 on audit.

- Additional Information To Be Provided By the Auditor: Providers ask that auditors provide the following information regarding audit activities:
    a. At the commencement of the audit:
        i. Name and contact information of the specific auditor(s);
        ii. Designate the location of the audit – either on site or through record submission;
        iii. If records are to be submitted, designate the specific manner by which such information is to be submitted;
        iv. A written disclosure of the sampling methodology to be employed in the audit.
    b. When extrapolation projection techniques are used, the extrapolation formula and the data/claims used in the sampling shall be provided to the provider and disclosed in the audit report.

- Auditor Qualifications: Regulations should specifically address the requisite training and qualifications that auditors must possess:
    a. Coding experience, including but not limited to applicable ICD, CPT and HCPCS codes;
    b. Any audit of records related to a decision regarding medical necessity must be done 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. The sampling methodology used to estimate overpayments must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimate methods, and shall be provided to the provider for review and comment.

- Composition of the Audit Team: The Department and contract auditors must ensure that the audit team includes qualified individuals, such as a

medical/dental professional who is experienced in the treatment, billing, and coding procedures subject to audit.

- Appeals: Provider engagement in the audit appeals process must include more than an "opportunity" to provide information at an exit interview.
    a. The audit appeals process should include at least 2 levels:
        i. Initial request for reconsideration; and
        ii. Second level appeal to an external party.
    b. The regulations should specify that a provider will not be subject to alleged overpayment re-payments or recoupment while an appeal is pending.

- Look Back Period: Regulations should expressly limit the time period or "look back" period for audits to claims that are not more than two years from the date the claim was filed.

- Timing and Frequency of Audits: The Department should endeavor to achieve greater transparency with providers in the scheduling and frequency of audits. The Department should complete the audit report in a timely fashion.

- Conference In Advance of Issuing a Preliminary Written Report: In any instance when an auditor determines that an extrapolated figure exceeds two hundred thousand dollars, the auditor shall review such preliminary audit findings with the provider before issuing a preliminary written report.

- Comparison of Preliminary Audit Findings vs. Final Written Report: The Department shall publish on its website an annual report comparing de-identified audit findings included in preliminary written reports against those included in final audit reports.

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