Connecticut Department of Social Services

Making a Difference

Written Testimony for the Human Services Committee
February 11, 2015

The Department of Social Services offers the following written testimony on a bill that impacts the agency.

H.B. No. 6550 AN ACT CONCERNING MEDICAID PROVIDER AUDITS

This proposal seeks to ensure that audits of Medicaid providers are conducted in a fair and reasonable manner.

Within the Department of Social Services, the Office of Quality Assurance ("QA") is responsible for ensuring the fiscal and programmatic integrity of all programs administered by the Connecticut Department of Social Services (Department), including programs in other agencies in which federal reimbursement is sought, as well as all administrative functions of the Department. QA is committed to the belief that program integrity can be best achieved through the fair application of proactive, creative, and coordinated initiatives designed to both prevent and recover improper payments.

The purpose of the audit function is to ensure compliance with the requirements of the Department's medical assistance programs. The need for compliance in the multi-billion dollar Medicaid program cannot be understated. Connecticut's medical assistance programs are governed by a vast array of policies, regulations and statutes. Most providers bill directly for goods and services rendered. It is QA's responsibility to ensure both the fiscal and programmatic integrity of these claims.

To fully comprehend the task assigned to QA, the Department's appropriated budget for SFY 2015 is approximately $3 billion, the largest of any state agency. The scope of the programs under QA, is well over $6 billion when the federal share of Medicaid expenditures is included. To ensure federal financial participation, the Department is required to audit all areas of Medicaid expenditures. As of July 1, 2014, there were more than 10,000 enrolled providers billing the Department. The Department processes over two million claims per month that are submitted by providers.

In SFY 2014, QA's Audit Division issued 168 final audit reports. This includes 153 issued by the Audit Division and 15 issued by its audit contractor, HMS. Of these audits, 20 have yet to be finalized as they are in the appeal process. In addition, the Department contracts with Myers & Stauffer to perform cost report audits of nursing facilities and similar providers. Myers & Stauffer issued 42 audit reports on behalf of the Department in SFY 2014.

The Audit Division is currently staffed with 34 people. The majority of the staff performs audits of payments made to providers enrolled in the Department's medical assistance programs.

The Audit Process

The Audit Division uses a variety of analytical tools and techniques to identify which providers to audit. It conducts a risk assessment analysis and considers successful initiatives employed in other states, current academic and public policy organizational analyses of health care issues, and program ideas and directives from the federal Centers for Medicare and Medicaid Services (CMS) and from the U.S. Department of Health and Human Services, Office of Inspector General (OIG).

The audit process is governed by subsection (d) of section 17b-99 of the Connecticut General Statutes. Providers are encouraged to review section 17b-99 in its entirety to gain a complete understanding of the audit process, but a summary is outlined below:

- The Audit Division gives the provider written notification of not less than thirty days prior to the commencement of an audit, unless it is determined that the health or safety of a recipient of services is at risk or the provider is engaging in vendor fraud. The written notification informs the provider of the length of the audit and the start date of the fieldwork.

- The Audit Division provides a preliminary written report of the audit to the provider that was the subject of the audit not later than sixty days after the Audit Division determines that the preliminary fieldwork, review and analysis of the audit has concluded.

- The provider has at least thirty days from receipt of this preliminary written report to provide documentation to the Department in connection with any discrepancy discovered and brought to the attention of such provider in the course of any such audit.

- Following the issuance of the preliminary written report, the Audit Division holds an exit conference with the provider for the purpose of discussing the preliminary report.

- The Audit Division produces a final written report concerning the audit. The final written report is given to the provider not later than sixty days after the date of the exit conference, unless the Audit Division agrees to a later date or there are other referrals or investigations pending concerning the provider.

- A provider aggrieved by a decision contained in the final written report may, not later than thirty days after receipt of the final report, request, in writing, a review of all items of aggrievement.

- Attorneys in the Department's Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH) have been designated by the Commissioner of Social Services to

preside over the reviews. OLCRAH shall issue a final decision following the review of all items of aggrievement.

- A provider may appeal a final decision issued by the OLCRAH to the Superior Court in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

- The Audit Division forwards a receivable notice to the Department's Financial Services Division for collection of any overpayments identified in the audit. The collection of the overpayment could be by check or offset from future medical payments to the provider. The Audit Division works with the provider to set up a payment plan that is both reasonable to the provider and the Department. Normally, collection of the receivable is stayed pending the outcome of the audit review.

- The Department's Financial Services Division returns to the federal government its proportionate share of the recovery. Pursuant to federal law, the state is obligated to repay the federal government its proportionate share of recovery within one year of properly identifying the amount of recovery.

The Use of Sampling and Extrapolation

The Audit Division utilizes random sampling and extrapolation to review the thousands of claims paid to a provider. This well-established auditing method is used by federal and state healthcare programs to efficiently evaluate payments to providers. The Connecticut Supreme Court upheld the use of extrapolation in the Department's medical assistance programs in case of *Goldstar Medical Services, Inc. et al. v. Department of Social Services*, 288 Conn. 790, 817 (2008) The Court noted:

> Specifically, in an administrative ruling entitled "Use of Statistical Sampling to Project Overpayments to Medicare Providers and Suppliers,'' the Secretary of Health and Human Services (secretary) concluded that, ''[i]n view of the enormous logistical problems in determining massive overpayments in social welfare programs," statistical sampling represents the ''*only feasible method available*'' of recouping overpayments. (emphasis in original)

Extrapolation is specifically permitted by state statute section 17b-99 (d) (3) under certain circumstances.

Audit Protocols

As required section 17b-99(d)(11) of the Connecticut General Statutes, the Department has developed and published specific audit protocols for numerous provider types, which are now on the Department's website. The protocols are published to educate the provider community on potential audit findings. Additionally, the protocols provide the Audit Division with specific written guidance to be used when performing audits.

Provider Training

The Audit Division has a history of providing free audit training to various provider associations. The recent amendment to 17b-99 requires the provision of free training to providers. As such, with the completion of the written protocols, the Audit Division has begun scheduling free training sessions with various provider groups and provider associations.

Continuous Improvement

The Department understands the importance of balancing the need to ensure program compliance with the rights of providers to have a fair and transparent review of their billings and payments. The Audit Division will continue to increase efforts to work with provider associations and communities with the goal of greater awareness of what is required as Medicaid providers and improved compliance.