

# CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

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February 24, 2015

**Written testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF) Inc. in support Proposed H.B. No. 5816 AN ACT CONCERNING AUDITS BY STATE AGENCIES.**

Good evening Senator Cassano, Representative Jutila and to the distinguished members of the Government Administration and Elections Committee. My name is Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's one hundred and sixty (160) member trade association of skilled nursing facilities and rehabilitation centers.

I am pleased to submit written testimony in support of proposed H.B. No. 5186 AN ACT CONCERNING AUDITS BY STATE AGENCIES.

As background, CAHCF was a member of a coalition of care providers who 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 included a well-intended and committed group of caregivers across the spectrum of healthcare and community care, including 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.

I have attached the coalition's recommendations to this written testimony. CAHCF asks the Government Administration and Elections Committee to give your careful consideration to addressing all of the coalition recommendations as the committee advances a more detailed version of H.B. 5816 for the consideration of the full Connecticut General Assembly. Finally, H.B. 5816 is similar in its purpose to Proposed H.B. No. 6550 AN ACT CONCERNING MEDICAID PROVIDER AUDITS, an important bill before the Human Services Committee, which CAHCF and the coalition of caregivers also supports.

Thank you and I would be happy to answer any questions you may have.

***For more information, contact Matthew V. Barrett, at [mbarrett@cahcf.org](mailto:mbarrett@cahcf.org) or (860) 290 9424.***

## 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.

## Summary of Proposed Changes

### 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 grievance, 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.