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Connecticut General Assembly Enacts Reforms to Medicaid Audit Statute

For many years, Medicaid providers have vigorously protested the Connecticut Department of Social Services' (DSS's) audit process and methodology, which many believe to be unfair and unnecessarily punitive. As a result, in past legislative sessions, the General Assembly enacted several modest changes to the Medicaid audit statute. This year, a coalition of providers and provider associations advocated for more meaningful reforms with the support of key legislators. In a hard-won victory for Medicaid providers, during the June Special Session, the General Assembly adopted significant additional changes to the DSS audit statute in Section 400 of the budget implementer bill (Senate Bill 1502, enacted as June Special Session, Public Act No. 15-5 or the "Act"). Note that the changes were originally listed as Section 403 of Senate Bill 1502 prior to its final passage. The changes took effect July 1, 2015.

SAMPLING AND EXTRAPOLATION

Many of the Act's revisions focus on DSS's use of extrapolation, which has been a continual source of confusion and aggravation for audited providers. First, the Act permits DSS to use extrapolation during an audit only if "the total net amount of extrapolated overpayment calculated from a statistically valid sampling and extrapolation methodology exceeds 1% of total claims paid to the provider for the audit period." The Act specifically defines a "statistically valid sampling and extrapolation

methodology" as one that:

- is validated by a statistician who has completed graduate work in statistics and has significant experience developing statistically valid samples and extrapolating the results of such samples on behalf of government entities,
- provides for the exclusion of highly unusual claims that are not representative of the universe of paid claims,
- has a 95% confidence level or greater (meaning there is a probability of at least 95% that the result is reliable), and
- includes stratified sampling (meaning a method of sampling that involves the division of a population into smaller groups known as strata based on shared attributes, characteristics or similar paid claim amounts) when applicable.

This revision marks a major change from the prior law. Previously, DSS was authorized to use extrapolation whenever DSS determined that there was a "sustained or high level of payment error," a term that was undefined; whenever DSS documented that educational intervention had failed to correct the level of payment error; or whenever the aggregate value of the provider's claims exceeded \$200,000 annually. In nearly all cases, extrapolation occurred because very few providers fell under the \$200,000 threshold.

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Second, the new law requires that the initial audit notification from DSS to the provider include a description of the statistically valid sampling and extrapolation methodology that will be used in conducting the audit.

Third, DSS is now prohibited from using extrapolation when the provider presents credible evidence that an error by DSS, or any entity with which DSS contracts to conduct an audit, caused the overpayment (although the overpayment, without extrapolation, must still be paid back to DSS).

The overall impact of these amendments is that, for the first time, DSS is required to use a “statistically valid sampling and extrapolation methodology” when determining an overpayment based on extrapolation, whereas the prior law allowed extrapolation, but did not expressly require any methodology. The prior law also required DSS to adopt formal regulations to carry out the audit process, including “the sampling methodologies associated with the [audit] process,” and that requirement is now repealed in the Act. DSS had previously proposed regulations, which had never made it through the legislature’s regulatory review process, and it appears that the legislature has instead chosen to regulate through new legislation.

UNINTENTIONAL OVERPAYMENTS

Another one of the Act’s focal points is preventing DSS from penalizing providers for unintentional overpayments. For example, the Act explicitly permits providers to submit evidence, in responding to DSS’s audit findings, “that errors concerning payment and billing resulted from a provider’s transition to a new payment

or billing service or accounting system.” Also, in a hearing requested by a provider aggrieved by DSS’s final audit report, the Act allows providers “to raise . . . that a negative audit finding was due to a provider’s compliance with a state or federal law or regulation.” Note that the Act does not expressly prohibit DSS from extrapolating findings based on such errors; however, the expectation is that DSS (or the hearing officer) will consider such evidence and remove related negative findings where the evidence is compelling.

APPEAL PROCESS

The Act also puts in place a more robust internal agency appeal process. A provider aggrieved by DSS’s final written audit report may now request a contested case hearing before a DSS hearing officer under the State’s Uniform Administrative Procedure Act, which includes an evidentiary hearing and a prohibition on ex parte contact with the hearing officer. The requirements for a contested case hearing can be found in General Statutes §§ 4-177 to 4-181a. The hearing officer must issue a final decision not later than 90 days following the close of evidence or the date on which final briefs are filed, whichever occurs later. This is a significant change in that, if requested, a full evidentiary hearing is now required before a hearing officer, rather than the previous procedure where a reviewing officer merely conducted a review of the written record and in many cases engaged in ex parte discussions with others, such as outside medical or dental consultants retained by the reviewing officer. Once the hearing officer issues the decision, the provider may appeal that decision to the Superior Court under General Statutes § 4-183. The Act does repeal the specific

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reference to judicial review in the Superior Court, but § 4-183 generally provides for the right to judicial review of a final decision in a contested case (i.e., an agency decision where a hearing is required). Accordingly, the audit statute no longer needs its own unique language allowing judicial review. Although judicial review is not new, the contested case hearing procedure allows a provider to create a better record for judicial review than under the previous procedure of a written record review by a reviewing officer. This is important because the Superior Court decides an appeal on the basis of the record developed before DSS.

DSS has in the recent past agreed not to recoup overpayments based on the final audit report until completion of the internal agency review process, but the Act now requires a stay of recoupment until the hearing officer issues a decision following the hearing, although only in the situation where “an overpayment amount [is] based on extrapolation.” Presumably a provider may still request a discretionary stay of the non-extrapolated overpayment. There is no specific provision addressing a stay of recoupment following the hearing officer’s final decision while the decision is appealed to court, although General Statutes § 4-183(f) allows the provider to apply to the court for a discretionary stay pending the outcome of court proceedings.

Other changes include:

- **Three Year Limit** - DSS will not be permitted to audit any claims paid more than 36 months from the date claims are selected for the audit.
- **Disclosure Requirements** - At the start of an audit, DSS must disclose (i) the name and contact information of the assigned

auditor or auditors, (ii) the audit location, including notice of whether such audit will be conducted on-site or through record submission, and (iii) the manner by which information requested must be submitted.

- **Scanned Copies Accepted** - A scanned copy of documentation supporting a claim is acceptable when the original documentation is unavailable.
- **Provider Education** - The law previously required that DSS provide education to providers to avoid “clerical” errors. The Act revised this requirement by removing the word “clerical.” As a result, DSS must educate providers more broadly on avoiding billing errors.
- **DSS Regulations** - As mentioned earlier, DSS is no longer required to adopt regulations pertaining to its provider audit practices. As a result, DSS also is no longer required to attach its regulations to the initial letter that it sends to providers before the start of an audit.
- **Audit Protocols** - By January 1, 2016, DSS must establish audit protocols for homemaker companion services, as it is already required to adopt for other provider types specified in the statute. The requirement that DSS issue audit protocols for other providers remains intact.

While the Act became effective on July 1, 2015, it is unclear how this new law will be applied to Medicaid audits that were in progress as of that date. Providers should understand all of the changes made by the Act so they can effectively advocate for themselves to ensure the best possible outcome.

This publication is a summary of legal principles. Nothing in this article constitutes legal advice, which can only be obtained as a result of a personal consultation with an attorney. The information published here is believed accurate at the time of publication, but is subject to change and does not purport to be a complete statement of all relevant issues.