HOUSE BILL REPORT
HB 1314

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to health care authority auditing practices.

Brief Description: Concerning health care authority auditing practices.

Sponsors: Representatives Caldier, Jinkins, DeBolt, Cody, Rodne, Griffey, Harris, Haler and Appleton.

Brief History:
Committee Activity:
Health Care & Wellness: 1/27/17, 2/17/17 [DPS].

Brief Summary of Substitute Bill

- Directs the Health Care Authority (Authority) to meet standards regarding auditing practices as related to the recovery of payments, auditing timelines, the use of statistical sampling, and the submission of records.
- Establishes requirements related to expertise and reporting for contractors performing audits on behalf of the Authority.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 17 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

Staff: Chris Blake (786-7392).

Background:

State medical assistance programs pay for health care for low-income state residents, primarily through the Medicaid program. These programs are administered by the Health

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Care Authority (Authority). Most of these programs are jointly funded with state and federal matching funds.

Audits of Providers Under State Medical Assistance Programs.

Statutory Audit Requirements.
The Authority is authorized to conduct audits and investigations of providers of health services to beneficiaries under the state medical assistance programs that it administers. To discover the provider's usual or customary charges, the Authority may examine random representative records as necessary to show accounts billed and received. If an overpayment is discovered, it may be offset by underpayments also discovered in the same audit sample.

If an audit shows an overpayment, the Authority must give notice to the provider demanding that the overpayment be paid within 20 days. The provider may request a hearing if the request is filed within 28 days of the notice.

Audit Requirements Under Authority Rules.
Providers must enter into agreements with the Authority to be approved as a provider. They must keep legible, accurate, and complete records to justify the services for which payment is claimed. Records must be available for six years from the date of service, unless state or federal law requires a longer period. Audits may be conducted either on-site or by a desk audit, or a combination of the two. The audits may be performed on a per-claim basis or by using a probability sample. If a sample is used, the Authority must provide, upon request, the sample size, the method of selecting the sample, the universe from which the sample was drawn, and any formulas used to determine improper payment amounts.

On completion of a draft audit report, the provider has 30 days to object and identify errors in the report. The objection may also include a request for a dispute resolution conference within 60 days. A final audit report may be appealed as provided by law.

Federal Audit Requirements for Medicaid.
Federal law requires each state administering a Medicaid program to establish and maintain an adequate internal control structure to ensure that Medicaid is administered in compliance with federal law. This control structure must be part of the approved state plan required to receive federal funding. Various government audit requirements establish the standards that the state must meet, including ensuring the propriety of expenditures reported for federal matching funds.

Summary of Substitute Bill:

Standards for Medicaid Audits.
Audits of health care providers in the medical assistance program by the Health Care Authority (Authority) must meet certain standards related to recovery of payments, auditing timelines, the use of statistical sampling, and the submission of records.

The Authority must make a reasonable effort to avoid reviewing claims that are currently being audited or have already been audited. Health care providers must be allowed to submit records related to an audit in electronic formats.

The Authority must provide at least 30 calendar days' notice in advance of an on-site audit, unless there is evidence of danger to public health and safety or fraudulent activities. The Authority must attempt to reach an agreed upon time and date with the health care provider. A preliminary report or draft audit finding must be produced within 120 days of receipt of requested information.

Findings of an overpayment or underpayment may not be based on extrapolation methods unless there is a sustained high level of payment error and educational intervention has failed to correct the level of payment error. Findings based on extrapolation, and the related sampling, must be statistically fair and reasonable. The sampling methodology must be validated as having a confidence level of 95 percent or greater.

The Authority must give health care providers a detailed explanation of any adverse determination that results in partial or full recoupment of a payment. The notification must be written and state the reason for the adverse determination, the specific criteria for the determination, an explanation of appeal rights, and, if applicable, the procedure for submitting the claim as a claims adjustment. The Authority must develop a process for improper payments identified by an audit to be resubmitted as claims adjustments.

Overpayments may not be recouped from a health care provider until all appeals have been completed. Health care providers must be offered the option of repaying the amounts owed according to a negotiated repayment plan of up to 12 months. If repayment is sought from a health care provider who is no longer under contract with the medical assistance program, the Authority must provide a description of the claim without requiring the health care provider to receive a court order.

The Authority must provide annual educational programs for health care providers on the topics of a summary of audit results, a description of common issues, problems and mistakes identified in audits, and opportunities for improvement.

Standards for Contractors Conducting Audits.
When conducting an appeal from a health care provider, a contractor that conducts audits on behalf of the Authority must employ or contract with a health care professional who practices in the same specialty, is board certified, and is experienced in the treatment and billing procedures as the provider appealing the audit.

These contractors must also compile annual metrics that the Authority must publish on its website. The metrics include:

- the number and type of claims reviewed and the number of records requested;
- the number of overpayments and underpayments identified and the associated monetary amount;
- the duration of the audits;
- the number of adverse determination and the rate of overturn on appeal;
- the number of formal and informal appeals filed by providers;

- the contractor's compensation structure and amount of compensation; and
- a copy of the Authority's contract with the contractor.

Substitute Bill Compared to Original Bill:

The substitute bill removes the application of the auditing standards to contracted auditors. The requirement that contractor auditors practice in the same specialty as the audited health care provider only applies to appeals.

The substitute bill removes the prohibitions against: (1) performing an audit of a health care provider within three years of the federal government conducting an audit of the health care provider; (2) reviewing claims that are more than three years from the date of initial payment; (3) reviewing claims that are paid through a capitated managed care program; (4) recovering payments in a medical necessity review in which prior authorization had been obtained; (5) using the same algorithm that was the basis of a prior audit performed by the federal government; (6) allowing technical deficiencies to be the basis for findings of overpayment; and (7) allowing clerical errors to be considered willful violations of program rules.

The substitute bill extends the requirement that a preliminary report be produced within 45 days of receiving all materials and a final report within 60 days of completing the initial review phase to 120 days of receiving the materials. The requirements to notify a health care provider within 10 days of completion of the initial audit review phase is removed. The minimum notice before scheduling an on-site audit is changed to 30 calendar days, from 30 business days.

The substitute bill removes the prohibition on funds in the Medicaid Fraud Penalty Account being disbursed to the Health Care Authority.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill establishes fair Medicaid practices. This bill fixes problems from the past few years with aggressive auditing practices that have caused many Medicaid providers to discontinue taking Medicaid patients. Providers want to do everything right and train staff correctly, but the state changes the rules frequently. Auditing procedures require that chart notes read like a book and everything must be complete. The audits are a long, stressful process that take a physical and emotional toll on providers. There needs to be training and stricter protections for providers and funds.

Dental hygienists are going through audits for services rendered going back as far as 2006, mostly for very minimally reimbursed services. Audit results over the past few years have shown confusion on the part of both the Health Care Authority (Authority) and the health care providers. Changes in the Authority personnel, such as eliminating the dental director, have created confusion and reduced communication about proper billing practices. The confusion discourages providers from accepting Medicaid patients.

Many states have passed legislation detailing how the auditing process is to take place and this bill will do that for Washington. The auditing process makes providers feel like criminals and it may weaken the strong network of providers if there is not a fair audit process. There must be a fair and predictable process for providers who are being audited. There must be balance between finding fraud and protecting providers from unreasonable burdens. This bill will assure that appropriately educated people are serving on the audit team. This bill protects the audit process, the individual providers, public dollars, and the network of dentists in Washington.

Because Medicaid rates are so low, when large amounts of money must be returned, the money comes out of the health care provider's pocket. There are no mediators to guide conversations between providers and auditors. The amounts of time for an audit requires that other dentists be brought in to cover the practice and the loss of business hurts the clinic. The extrapolation process is unclear and it is not fair to assume that once a mistake is made it is made all of the time.

(Opposed) None.

Persons Testifying: Representative Caldier, prime sponsor; Melissa Johnson, Washington Dental Hygienists Association; Jason Gibbons; Camille Pieterick; and Charlina Stewart, Smilesonrisas Dental.

Persons Signed In To Testify But Not Testifying: None.