Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1314

Brief Description: Concerning health care authority auditing practices.

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

Brief Summary of Bill

- Directs the Health Care Authority (Authority) and its contractors 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.

Hearing Date: 1/27/17

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 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.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

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 Bill:

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

The Authority and its contractors may not perform an audit of a health care provider within three years of the federal government conducting an audit of the health care provider. The Authority may not review claims that are more than three years from the date of initial payment, that are paid through a capitated managed care program, or that are currently being, or have already been, audited. Health care providers must be allowed to submit records related to an audit in electronic formats.

Several timelines are established for audits of service providers. The Authority and its contractors must provide at least 30 days' notice in advance of an on-site audit and attempt to reach an agreed upon time and date. After the initial audit review phase has been completed, the Authority and its contractors must notify the health care provider within 10 days. A preliminary report must be produced within 45 days of receipt of requested materials. A final report must be produced within 60 days of the initial review phase.

The Authority may not use the same algorithm that was the basis of a prior audit performed by the federal government. 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.

Payments may not be recovered in a medical necessity review if the health care provider had received prior authorization for the service and it was performed accordingly. A finding of overpayment may not be based upon technical deficiencies if the health care provider demonstrates that the claim meets the definition of an allowable cost. Clerical errors do not constitute a willful violation of medical assistance rules, unless there is proof of intent to commit fraud or violate program rules.

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.

Overpayments may not be recouped from a health care provider until all appeals have been completed. Health care providers must be offered reasonable repayment plans. 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 develop a process for improper payments identified by an audit to be resubmitted as claims adjustments.

The Authority and its contractors 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.

Funds in the Medicaid Fraud Penalty Account may not be disbursed to the Authority.

Standards for contractors conducting audits.

Contractors that conduct audits of the medical assistance program 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 being audited. These contractors must also compile annual metrics that the Authority must publish on its web site. 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.

Appropriation: None.

Fiscal Note: Available.

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