**Washington State**
**House of Representatives**
**Office of Program Research**

# BILL ANALYSIS

# Health Care & Wellness Committee

# HB 1712

**Brief Description**: Concerning audit procedures to assist medicaid providers.

**Sponsors**: Representatives Harris, Riccelli, Rodne, Van De Wege and Caldier.

**Brief Summary of Bill**

- Directs the Health Care Authority (Authority) to develop audit protocols to assist Medicaid providers and post the protocols on the Authority's web site.
- Establishes timelines for audits of Medicaid providers relating to notice of an audit, the issuance of a preliminary report, and the issuance of a final report.
- Prevents the Authority from using extrapolation in an audit, except in specified circumstances.

**Hearing Date**: 2/17/15

**Staff**: Chris Blake (786-7392).

**Background**:

The Health Care Authority (Authority) administers the Medicaid program which is a state-federal program that pays for health care for low-income state residents who meet certain eligibility criteria. Among the requirements that states and service providers must comply with under the federal program are provisions to submit information for the purpose of determining improper payments under Medicaid.

The Authority maintains the responsibility for conducting audits and investigations of Medicaid providers at the state level. If an audit shows an overpayment, the Authority must give written notice to the provider demanding repayment, less any underpayment that the audit revealed. The provider may either submit the payment to the Authority within 20 days or request an adjudicative proceeding to contest the overpayment notice within 28 days. Adjudicative proceedings are governed by the Administrative Procedures Act.

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*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.*

The Authority regulations allow it to use extrapolation methods to determine an improper payment from a probability sample. If extrapolation methods are used, the provider is entitled to know: the sample size, the method used to select the sample, the universe from which the sample was drawn, and any formulas or calculations used to determine the amount of the improper payment.

**Summary of Bill**:

By January 1, 2016, the Health Care Authority (Authority) must post audit protocols on its web site to assist Medicaid providers in meeting state and federal requirements. There must be separate protocols for different types of service providers or categories of service, including home health agencies, drug and alcohol treatment centers, durable medical equipment, hospital outpatient services, physician and nursing services, dental services, and emergency and nonemergency medical transportation services. The audit protocols may not be relied upon as enforceable standards.

Several timelines are established for audits of service providers that must be met by the Authority or entities that conduct audits on behalf of the Authority. They must send written notice 30 days in advance of any scheduled on-site audit. They must hold an exit conference on the last day of an on-site audit, unless outstanding circumstances arise. They must issue a preliminary report within 45 days of completing a review of a provider's records. They must issue a final written report within 60 days of completing the audit or holding the exit conference.

The Authority or entities that conduct audits on behalf of the Authority must have on staff a medical or dental professional who is licensed in Washington and is experienced in the treatment, billing, and coding procedures used by the provider being audited.

If the Authority contracts with an entity to conduct audits on the Authority's behalf, the entity must be paid on a flat fee basis.

Findings of an overpayment or underpayment may not be based on extrapolation methods unless:

- there is a sustained or high level of payment error;
- educational intervention has failed to correct the level of payment error; or
- the total value of the claims exceed $200,000 annually.

Findings based on extrapolation, and the related sampling, must be statistically fair and valid. Clerical errors do not constitute a willful violation of Medicaid rules, unless there is proof of intent to commit fraud or violate program rules.

**Appropriation**: None.

**Fiscal Note**: Requested on February 12, 2015.

**Effective Date**: The bill takes effect on January 1, 2016.