FINAL BILL REPORT
SHB 1314

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Synopsis as Enacted

Brief Description: Addressing health care authority auditing practices.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Caldier, Jinkins, DeBolt, Cody, Rodne, Griffey, Harris, Haler and Appleton).

House Committee on Health Care & Wellness
House Committee on Appropriations
Senate Committee on Health Care
Senate Committee on Ways & Means

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.

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 file a request for a hearing 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

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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:

Standards for Medical Assistance Program 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 by the Authority or another governmental entity, or have already been audited by the Authority. 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 topics including 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 used by 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.

Votes on Final Passage:

House	98	0	
Senate	49	0	(Senate amended)
House	98	0	(House concurred)

Effective: July 23, 2017