HOUSE BILL 2930

By Sargent

AN ACT to amend Tennessee Code Annotated, Title 9, Chapter 8 and Title 71, Chapter 5, relative to health care providers.

WHEREAS, the Deficit Reduction Act of 2005 established the Medicaid Integrity Program (“MIP”) to combat fraud, waste and abuse in the Medicaid program; and

WHEREAS, the Secretary of Health and Human Services enters into contracts with eligible entities to carry out the activities of the MIP; and

WHEREAS, the MIP does not have restrictions on how far it can “look back” to identify overpayment, but as a general rule, the MIP expects to follow state policies with regard to “look back” periods; and

WHEREAS, any overpayment identified by the audit will be pursued by the state in accordance with state law; and

WHEREAS, the providers are entitled to full appeal rights and adjudication of the state’s actions pursuant to an audit in accordance with state law; now, therefore

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following new sections:

§ 71-5-151. This section and §§ 71-5-152 - 71-5-157 shall be known and may be cited as the “TennCare Provider Audit and Recoupment Act.”

§ 71-5-152. As used in §§ 71-5-151 - 71-5-157, unless the context otherwise requires:

(1) "Centers for medicare and medicaid services" (CMS), means the agency within the United States department of health and human services that is

responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act;

(2) “Commissioner” means the commissioner of finance and administration;

(3) “Department” means the department of finance and administration;

(4) "Medicaid integrity program" (MIP), means the program established in § 1936 of the Social Security Act by the Deficit Reduction Act of 2005;

(5) “Provider” means any person or entity directly providing medical or behavioral services to a TennCare enrollee. “Provider” does not include pharmacy or pharmacist; and

(6) “TennCare program” means the program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the state of Tennessee and any successor program.

§ 71-5-153.

(a) When the state conducts an audit of a provider's records pursuant to the TennCare program, the audit shall be conducted in the following manner:

(1) Written notice shall be given to the provider at least three (3) weeks prior to the commencement of an on-site audit;

(2) There shall be a ten (10) day discussion period following receipt of the notification, in order for the provider and auditor to clarify the request or the need for the record submission;

(3) The finalized notice shall describe in detail the provider’s records for inspection, either for a desk audit or an on-site audit;

(4) The finalized request shall clearly define milestone dates pertaining to records' requested due dates, permissible extensions of dates, the timelines for informal reconsideration, and deadlines for requesting a formal appeal;

(5) The records subject to the request shall be no more than the number permitted by the formula currently in use by CMS for the Medicare RAC program, not to exceed two-hundred (200) per forty-five (45) days for all MIP audits involving medical record requests;

(6) The records request shall include, at a minimum, the following information:

(A) Name;

(B) Date of service;

(C) Date of birth;

(D) Procedure code;

(E) Social security number; and

(F) Medicaid identification number;

(7) The records requested must directly relate to claims for reimbursement submitted by the provider;

(8) For on-site audits, the inspections shall be conducted at reasonable times during regular business hours, and the auditor shall make such arrangements as are necessary for the reproduction of records on site;

(9) For desk audits, the auditor shall give the provider a reasonable period of time, which shall be not less than forty-five (45) business days from receipt of the finalized request, to provide the records

taking into account the scope of the request, the time frame covered, and the reproduction arrangements available to the provider;

(10) Requested records may be produced by mail, fax, CD, DVD or any other electronic method. If the provider produces electronic media records, the provider shall also provide the data layout; and

(11) In the event the provider requests an extension of due dates beyond the forty-five (45) day period, the auditor shall grant a reasonable extension of due dates.

(b) Prior to commencement of the audit, the auditor shall schedule an entrance conference to explain the objectives of the audit and attempt to address questions from the provider.

(c) The audit and recovery activities may relate to claims that have been paid within three (3) years of the date of issuance of the medical record request letter or demand letter. Notwithstanding the provisions of this subsection (c), any claim that was paid prior to October 1, 2007, shall not be subject to audit and recovery activities pursuant to §§ 71-5-151 - 71-5-157.

(d) Notwithstanding any law to the contrary, the accounting practice of extrapolation to determine overpayments shall not be used in any audit of a provider that is conducted pursuant to §§ 71-5-151 - 71-5-157. Individual claims must be reviewed.

(e) The provider shall be given a preliminary audit report. Following receipt of the preliminary audit report, the provider shall be allowed at least thirty (30) days in which to respond and produce documentation to address any discrepancy found during the audit.

(f) Before or at the time of delivery of the final audit report, the provider shall be provided with a written explanation of the appeals process, including the name, address and telephone number of the person to whom an appeal should be addressed. If it is determined at any stage of the appeal that the audit report or any portion of the audit report is unsubstantiated, the state shall be precluded from seeking recoupment of funds based on the unsubstantiated portion of the audit report.

(g) Recoupment of any disputed funds shall only occur after the final decision on appeals.

§ 71-5-154.

(a) Upon issuance of the final audit report to the provider, the state shall hold an informal meeting. The informal meeting shall include the provider, or an authorized representative of the provider, and a representative of the department who has the authority to determine whether the funds will be sought for recovery and the amount that will be sought by the state. The purpose of an informal meeting is to offer the provider an opportunity to be heard and to negotiate a withholding of an amount or repayment of an amount alleged to be due to the state.

(b) The provider shall have sixty (60) days from the date of the informal meeting to challenge the findings of the final audit report with the state by filing an appeal to the recoupment determination committee to determine whether funds are due to the state.

§ 71-5-155.

(a) The commissioner shall appoint a recoupment determination committee. The committee shall approve regulations pursuant to this section prior to such regulations taking effect, assist the commissioner in the implementation of such regulations, and advise the commissioner, at the commissioner's request, on issues relating to the state's determination of the amount due to the state from a provider. Upon the filing of an appeal with the committee by a provider, the committee shall review the final audit report and determine what funds, if any, are due to the state. The decision of the committee is final unless contested by the provider.

(b) The committee shall be composed of ten (10) voting members appointed by the commissioner as follows:

(1) Two (2) members shall represent hospitals and shall be appointed from a list of nominees submitted by the Tennessee Hospital Association;

(2) Two (2) members shall represent long term care providers and shall be appointed from a list of nominees submitted by the Tennessee Health Care Association;

(3) One (1) member shall be a physician licensed to practice medicine and surgery under title 63, chapter 6, who is a TennCare provider, and who shall be appointed from a list of nominees submitted by the Tennessee Medical Association;

(4) Two (2) members shall represent the TennCare health insurance industry, one (1) of whom shall be the medical director of a TennCare managed care contractor;

(5) One (1) member shall be a pharmacist and shall be appointed from a list of nominees submitted by the Tennessee Pharmacists Association;

(6) One (1) member shall represent TennCare durable medical equipment providers; and

(7) One (1) member shall represent the TennCare home health care providers.

(c) Each nominating organization shall include at least three (3) nominees for each committee position for which it is requested to submit nominations. If the commissioner finds a list of nominees unsatisfactory, the commissioner shall return the list to the submitting organization. The organization shall submit another list within thirty (30) days. This process shall continue until the commissioner appoints a member from one (1) of the lists of nominees. If an organization that is required to submit a list of nominees fails to do so within thirty (30) days of a request for the list by the commissioner, then the commissioner may appoint a member of the commissioner's own choosing.

(d) The members of the committee shall be appointed for terms of four (4) years. Each member of the committee shall, upon the expiration of such member's term, be eligible for reappointment and shall serve until a successor is appointed and qualified.

(e) Members of the committee shall serve without compensation but, when engaged in the conduct of their official duties as members of the committee, shall be entitled to reimbursement for travel expenses in accordance with uniform regulations promulgated by the department of finance and administration and approved by the attorney general and reporter.

§ 71-5-156.

(a) There is conferred upon the commissioner the power to enforce §§ 71-5-151 - 71-5-157 that relate to the determination of the amount to be sought by the state in its recoupment efforts as a result of an audit by the state or pursuant to the MIP.

(b) The commissioner is authorized to promulgate rules and regulations pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, which implement §§ 71-5-155 - 71-5-156. Prior to any such rules and regulations becoming effective, the rules and regulations must first be approved by a majority vote of the members of the recoupment determination committee.

§ 71-5-157.

(a) If a provider disagrees with the decision of the recoupment determination committee, the provider shall have thirty (30) days to either:

(1) File a petition for a contested case hearing pursuant to the Uniform Administrative Procedures Act, complied in title 4, chapter 5; or

(2) Pay the state in accordance with the agency's decision and then seek recovery of the funds paid to the state by filing a petition with the claims commission.

(b) The state may waive the recovery or adjustment of all or part of the overpayment specified in the final audit report if it would be inequitable, uncollectible, or administratively impracticable.

(c) In order to collect the amounts finally determined by the state to be an overpayment, the state or its TennCare contractor may withhold subsequent payments to which the provider is or becomes entitled and apply the amount withheld as an offset. The state shall establish by rule the rate at which an

overpayment may be offset, with provision for a reduction of such rate upon a good cause shown by the provider that the rate at which payment will be withheld will result in an undue hardship for the provider. In determining whether to grant a good cause reduction, the state shall consider the impact of collecting the amount on the quality of patient care and the financial viability of the provider. The state may also take such other steps administratively as are available for the collection of the amounts determined to be overpayment.

(d) If a claim is ultimately found to have been submitted in error, the provider shall have ninety (90) days to resubmit the claim.

(e) Sections 71-5-151 - 71-5-157 shall not apply to any investigative audit which involves TennCare fraud.

SECTION 2. Tennessee Code Annotated, Section 9-8-307(a)(1)(L), is amended by adding the following language immediately following the existing language "local education insurance committee;"

Provided further, that recovery by the state of payments made to providers in the TennCare program based on audits performed pursuant to the Medicaid Integrity Program shall be considered contracts for purposes of this subsection (a) in order for the commission to determine if the state owes those recovered payments back to the providers.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it.