PROPOSED GUIDELINES FOR THE EXERCISE OF DISCRETION TO SEEK EXTRAPOLATED RECOUPMENT AND IMPOSE CMPS

The Idaho Department of Health and Welfare (the "Department") has discretion in choosing among remedies and penalties following provider billing audits conducted by its Medicaid Program Integrity Unit. Idaho Code § 56-209h and its implementing regulations, IDAPA § 16.05.07, authorize the Department, upon adverse audit findings, to impose remedial action ranging from the issuance of a warning and provider education (IDAPA § 16.05.07.270.01) to exclusion of the provider from the Medicaid program (IDAPA § 16.05.07.240).

Medicaid providers have requested and are entitled to greater clarity concerning when and how the Department will opt to impose particular remedies under IDAPA § 16.05.07. This guidance addresses the circumstances in which the Department will seek to impose two such remedies: extrapolated recoupment and civil monetary penalties.

I. EXTRAPOLATED RECOUPMENT

The Department will exercise its discretion such that it will seek to recover overpayments calculated by the use of probability sampling and extrapolation under IDAPA § 16.05.07.100 only when the sampling has been performed in accordance with generally accepted statistical standards and procedures (consistent with IDAPA § 16.05.07.100.02) and each of the following conditions has been met:

1. There is a determination of a high error rate, at least in excess of ten percent (10%) among sampled claims, for a particular service code representative of at least a three-year time period;

    a. For an error rate to be considered high, the error rate must be in excess of ten percent (10%) when calculated as the ratio of the number of erroneous claims to the total number of sampled claims and when calculated as the ratio of overpayments to the total amount of reimbursement for all sampled claims;

2. There is a determination that documented educational intervention has failed to correct the level of payment error; and

3. The aggregate value of the claims for the provider of the particular service code in the relevant time period exceeds two hundred thousand dollars ($200,000) on an annual basis.[1]

When each of these conditions has been met, the Department shall calculate the amount it demands in extrapolated recoupment using the methodology adopted by the Centers for Medicare and Medicaid Services ("CMS") with respect to audits of Medicare providers as set forth in the Medicare Program Integrity Manual, Chapter 8 ("Administrative Actions and Statistical Sampling for Overpayment Estimates").[2] In particular, the Department shall seek to recover an amount no

[1] Adapted from Utah Admin. Code R. 414-512.
[2] Chapter 8 of the Medicare Manual can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c08.pdf

greater than the lower limit of a one-sided, ninety percent (90%) confidence interval. *See* CMS, Medicare Program Integrity Manual ch. 8, ¶ 8.4.5.1.

II. CIVIL MONETARY PENALTIES

Absent evidence of fraud or knowing abuse, the Department is authorized by both statute and regulation to impose civil monetary penalties ("CMPs") only when an audit demonstrates that the provider has "repeatedly or substantially" failed to comply with Medicaid rules and regulations. Idaho Code § 56-209h(6)(f),(8); IDAPA § 16.05.07.230.06 & .235. Neither the statute nor the regulation defines the terms "repeatedly" or "substantially" as used in this context. The absence of such definition has led to confusion among providers and could lead to inconsistent imposition of CMPs. Therefore, this guidance sets forth the Department's understanding of these terms and thereby the circumstances in which the Department will seek to impose such remedies.

The Department interprets the word "repeatedly" to mean that a provider commits significant errors in successive audits despite written guidance and education to the provider following an earlier audit. Thus, the Department will seek to impose CMPs on the basis that audit results show repeated violations only if each of the following is demonstrated:

1. A previous audit found that the provider had failed to follow Medicaid rules and regulations at a high rate, defined to be an error rate for a particular service code in excess of ten percent (10%) when calculated as the ratio of the number of erroneous claims to the total number of sampled claims and when calculated as the ratio of overpayments to the total amount of reimbursement for all sampled claims of all similar claims audited;

2. Following the earlier audit, the Department issued the provider a warning and written education and guidance sufficient for the provider to avoid or reduce the incidence of that particular error in the future;

3. A subsequent audit concerning claims submitted after the provider has had a reasonable opportunity to act upon the Department's education and guidance finds that the provider committed the same error with respect to the particular service code at a rate equal to or greater than the error rate found in the prior audit; and

4. The provider is unable to demonstrate that it had engaged in a good faith attempt to implement the Department's earlier education and guidance.

The Department interprets the word "substantially" to mean in the majority of instances resulting in significant overpayment by the Medicaid program. Therefore, the Department will seek to impose CMPs on the basis that a single audit revealed that a provider failed "substantially" to follow Medicaid rules and regulations only if the provider committed the error as to a particular service code in a majority (*i.e.*, greater than 50 percent of all similar claims audited) and, as a result, the Medicaid program overpaid the provider an amount in excess of two hundred thousand dollars ($200,000).