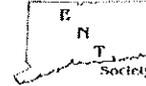
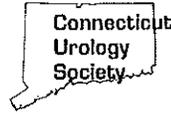




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**Testimony of the Connecticut State Medical Society
House Bill 6550 An Act Concerning Medicaid Provider Audits
Human Services Committee
February 11, 2015**

Senator Moore, Representative Abercrombie and members of the Human Services Committee, on behalf of the physicians and physicians-in-training of the Connecticut State Medical Society (CSMS), we thank you for the opportunity to provide testimony on **House Bill 6550 An Act Concerning Medicaid Provider Audits**. We thank this committee for its ongoing efforts to establish a fair and transparent audit process that encourages Medicaid participation and does not place further barriers on access to care to the growing numbers of Medicaid recipients in Connecticut.

CSMS understands the ever-increasing pressure on both governmental and private payers to reduce healthcare costs, and that payers, including the State, will continue to use audits to identify alleged overpayments. However, Connecticut physicians and their office staffs face a significant challenge in preparing for and responding to audits and financial reviews conducted by various private payers, as well as Medicare and Medicaid audits.

Certain methodologies can be implemented to ensure fair and just treatment of physicians when conducting audits that must balance the understandable needs of the state to identify deficiencies or overpayments. We understand the intent of HB 6550 to (1) establish clear parameters governing the use of extrapolation, (2) set standards for statistical sampling, (3) establish a process for physicians and other network providers to challenge findings and (4) increase transparency, outreach and education. We offer these comments regarding statutory or regulatory changes necessary to ensure inherent fairness and transparency throughout the process.

We appreciate the need for clear parameters governing the use of extrapolation. Extrapolation methodologies require a complex statistical formula. To be accurately used, such formulas must be developed by a statistician knowledgeable of both extrapolation tied to sampling as well as the Medicaid program in Connecticut. Furthermore, if used to calculate an alleged overpayment amount, the extrapolation formula must be provided in the audit report with all of the underlying parameters and variables employed. To be accurately done, extrapolation must be done by an experienced statistician and the name and credentials of the statistician performing the analysis must be supplied as part of the audit findings for full transparency and understanding of the process employed to determine the amount owed or to be paid.

Extrapolation must be based on a statistically valid random sample, using stratification when appropriate. A statistically valid random sample for a medical audit is a sample where every single claim has an equal opportunity to be included within that sample. A biased sample can result in a vast over-calculation of overpayment amounts when extrapolated to a larger universe. In other words, if a sample represents a higher average paid amount than the universe of claims, it may translate into a higher average overpayment amount than would be calculated from a true random sample. For example, in a universe of 10,000 claims, a difference of \$10.00 could result in an overestimate of \$100,000 in the overpayment demand when the extrapolation methodology does not use a statistically valid random sample. This is a key reason why a statistician, who is experienced in statistically valid random sampling, is essential to the audit process when extrapolation is used.

CSMS feel strongly that such statistical analysis and statistical guidelines must be contained in statutory or regulatory language if the extrapolation methodology is going to be used. Without these statistical protections, the extrapolation process has significant potential to be fraught with errors and inaccuracies, potentially requiring physicians who are audited to refund monies not owed to the state. This could have a further damaging impact on the network of physicians willing to see patients covered by Medicaid.

In addition to the necessary constraints on the extrapolation process, additional statutory and/or regulatory protections are necessary for physicians undergoing Medicaid audits. Currently, physicians participating in the Medicaid program face an uncertain future as federal funding provided to states through the Accountable Care Act (ACA) to increase Medicaid rates terminated on December 31, 2015. The potential for significant reductions in reimbursement, coupled with the uncertainty and unfairness in the Medicaid audit program, would provide significant and potentially insurmountable barriers for continued participation in the program by many physicians. For many, the costs associated with audits both financially and through the drain on staff resources outweigh the benefits of participation. Ensuring a fair and just audit process will help to retain quality physicians in Medicaid program serving a significantly increasing population.

CSMS also believes that statutory or regulatory guidance is needed with regard to the audit notice provided to physicians. Presently, the audit notice is lacking in any specificity necessary to comply with the audit request. The audit notice should be provided to physician practices with advance written notice sent by certified mail at least 30 business days prior to an audit. Additional information regarding the records required, manner in which they are to be submitted, and codes and modifiers in questions must be provided so that the practice can sufficiently and appropriately prepare for the audit, including collecting any necessary documentation that could substantiate or refute any assertion or allegation.

In addition, CSMS believes that statutory and/or regulatory guidance must state that all individuals performing medical audits have appropriate knowledge and experience in coding, including applicable ICD, CPT®, and HCPCS codes, guidelines and conventions. Additionally, auditors must be familiar with the format and contents of medical records and claims forms. Individuals auditing medical records for issues of coding and documentation should be certified in coding, with at least one year's auditing and/or coding experience. Further, those auditing medical records related to decisions of medical necessity must be licensed in a clinical discipline which provides the appropriate expertise to determine whether clinical tests and procedures were medically necessary without the benefit of examining the patient.

Statutes and/or regulations should specify what must be contained within the reports detailing the audit findings. The audit report should clearly identify any errors discovered in the audit, specifying all medical and reimbursement policies and procedures used in determining the outcome of the audit and providing a copy of these policies and procedures to the physician as part of the audit report. If the auditor is unable to pinpoint or provide the specific medical reimbursement policies and procedures being relied upon, then the overpayment request specific to those policies and procedures should not be allowed. It is only fair that physicians be given copies of the medical policies and procedures documentation being relied upon by the auditor. If those policies and procedures are not available for any reason, the findings should be disallowed. Additionally, the audit report should identify underpayments to the physician practice. The audit report should be provided within 30 days of the completion of the audit. Where repayment is sought, the audit report should clearly describe how the overpayment amount was calculated and what the process is for repayment.

We applaud the inclusion of language to require the establishment of acceptable methods by which physicians and other network providers can challenge extrapolated findings of overpayments. While the ability to challenge extrapolation is critical, we feel that a more formal appeals process should be established regarding the entire audit process as there is presently an inherent lack of due process afforded to those being audited.

We also strongly believe that any audit appeals process should have at least two levels: an initial request for reconsideration and a second level appeal to an external qualified third party. Furthermore, any decision to deny reconsideration should be made by a qualified physician familiar with the services and procedures in question. With regard to the second level of appeal, an external qualified third party should be utilized and such third party should be independent from the DSS staff. Finally, it should be specified that that physicians are not subject to alleged overpayment re-payments or recoupments while any appeal is pending and until a final decision upon appeal is reached.

Additional parameters should also place limitations on the "look back" period for audits to provide more consistency with industry standards. State law currently limits the period to 18 months for commercial payers. For fairness and consistency, the same timeframe should exist for the Medicaid program, especially in light of all of the regulatory and statutory changes to the program year after year.

CSMS appreciates the opportunity to provide these comments on HB 6550. We also appreciate the opportunity to provide suggestions for additional statutory and/or regulatory provisions that we believe are necessary to ensure a fair and transparent audit process that will help retain physician participation in the Medicaid program and provide quality medical care to the patients of Connecticut. CSMS and its physicians do not want a process to be implemented that is even more onerous than the current process by which audits occur, further driving physicians from Medicaid participation. In fact, a recent CSMS survey of membership found that in addition to low reimbursement levels, the number one reason cited for lack of network participation is the administrative barriers placed on physicians, including audits and reviews that lack any semblance of transparency and appeal.

We look forward to the opportunity to work with members of this committee in our ongoing efforts to create a fair and transparent Medicaid audit process.

Summary of Proposed Changes

Department of Social Services Provider Audit Process

A coalition of care providers met in 2014 to identify key measures necessary to achieve transparency in audit practices, clarity for Medicaid providers, and fairness of the audit process. The coalition includes the Connecticut Hospital Association, the Connecticut Association for Healthcare at Home, the Connecticut Association for Health Care Facilities, the Connecticut State Medical Society, LeadingAge Connecticut, the Connecticut State Dental Association, the Connecticut Community Providers Association, the Connecticut Pharmacist Association, the CT Homemaker & Companion Association, Companions and Homemakers, CVS Health, Quest Diagnostics, the Northeast Pharmacy Service Corp., and the Connecticut Association of Community Pharmacies, Inc. The coalition's recommendations are described below.

Extrapolation

Extrapolation is a statistical technique for inferring what occurred outside the range of what was actually measured, and should not be used in the following circumstances:

1. **Across Disparate Services:** Do not extrapolate across disparate services, apply only to like claims.
2. **ED vs. Non-ED Claims:** Claims related to emergency medical care should not be extrapolated to claims not related to emergency care.
3. **Observation Care:** Claims for any appropriate medical care for anyone in observation status after 23 hours.
4. **Clerical Errors:** Circumstances involving a clerical error, especially when there was no financial impact resulting from the error.
5. **Unintentional Overlap in Services:** When two unrelated providers submit claims for serving Medicaid clients during the same time period, caused by circumstances beyond their control.
6. **Transition to New Billing Procedures:** When payment or billing errors result from a transition to a new billing procedure.
7. **Prior to Policy Effective Date:** When claims were submitted prior to the issuance of the specific audit and/or reimbursement policy that is the subject of the audit.
8. **No Notice of Service Plan Amendment:** When the provider demonstrates that it was not made aware of a plan amendment prior to providing the service.
9. **Unique or Rarely Used Claims:** Unique claims should be dealt with individually.
10. **Outlier Claims:** Outlier claims should be dealt with individually.

Sampling Methodology

Extrapolation projections must be based on a statistically valid random sample, as reviewed by a statistician or by a person with equivalent expertise in probability sampling and estimation methods.

1. **Early Disclosure of Sampling Methodology:** The methodology should be disclosed at the outset of the audit.
2. **Sample Stratification:** Claims should only be pulled that are specific to the procedure or service identified by the CPT code.
3. **Use of Median vs. Average:** The median should be applied in cases in which claims with multiple services are being extrapolated to reduce the overweighting of multiple claims.
4. **Paid Claims Only:** The universe of claims to be sampled cannot exclude claims for which no payment was issued.

Summary of Proposed Changes

Department of Social Services Provider Audit Process

Fairness of the Audit Process

These measures should be implemented to ensure the fairness of the audit process:

1. **Compliance with Federal and State Rules:** A provider should be permitted to raise, at any time, including as an item of grievance, that its compliance with a state or federal law or regulation explains or negates a negative finding in an audit.
2. **Additional Information to be Provided by the Auditor:** Auditors should provide the following information regarding audit activities:
 - a. At the commencement of the audit:
 - i. The name and contact information of the specific auditor(s);
 - ii. The audit location – either on site or through record submission;
 - iii. The manner by which information shall be submitted; and
 - iv. The sampling methodology to be employed in the audit.
 - b. When extrapolation is used, the formula and data/claims used in the sampling shall be provided to the provider and disclosed in the audit report.
3. **Auditor Qualifications:** Auditors must undergo training and possess certain qualifications:
 - a. Auditors must have coding experience, including but not limited to applicable ICD, CPT, and HCPCS codes.
 - b. Decisions regarding medical necessity must be made by a professional licensed in the same clinical discipline.
 - c. Auditors must have general knowledge of the particular provider services under audit and the Medicaid program they are auditing.
 - d. Sampling methodology must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimate methods.
4. **Composition of the Audit Team:** The team must include qualified individuals, such as medical or dental professionals experienced in treatment, billing, and coding procedures.
5. **Appeals:** The audit appeals process should include at least 2 levels: (1) the initial request for reconsideration and (2) a second level appeal to an external party.
6. **No Recoupment While Appeal is Pending:** A provider will not be subject to alleged overpayment, re-payments, or recoupment while an appeal is pending.
7. **Look-Back Period:** Expressly limit the “look-back” period for audits to claims that are not more than two years from the date the claim was filed.
8. **Timing and Frequency of Audits:** Achieve greater transparency in the scheduling and frequency of audits. The Department should complete the audit report in a timely fashion.
9. **Conference before Issuing a Preliminary Written Report:** When an extrapolated figure exceeds \$200,000, a conference must be held before the auditor issues a preliminary written report.
10. **Comparison of Preliminary Audit Findings vs. Final Written Report:** Publish an annual report comparing de-identified audit findings included in preliminary written reports against those included in final audit reports.