

Statement Before
The Human Services Committee
Wednesday, February 11, 2015

Re: Proposed Bill 6550: An Act Concerning Medicaid Provider Audits

Good Evening Senator Moore, Representative Abercrombie and members of the Human Services Committee. My name is Margherita Giuliano and I am both a pharmacist and the Executive Vice President of the Connecticut Pharmacists Association. The Connecticut Pharmacists Association is a professional organization representing more than 800 pharmacists in the state of Connecticut. I am here today in support of proposed bill 6550: **An Act Concerning Medicaid Provider Audits.**

The proposed audit legislation is simply asking for fair and reasonable treatment of providers during the audit process. I want to focus specifically on audits to our pharmacies because we are different from other Medicaid providers. One of the services we provide involves a product with a real cost that pharmacies are obligated to pay for no matter what. I think that is an important distinction especially when we get into the discussion on extrapolation.

I want to be very clear that we are not against audits. When looking at the federal laws concerning audits, their genesis was to serve a valid purpose: (1) Report fraud and abuse information to the Department; and (2) Have a method to verify *whether services reimbursed by Medicaid were actually furnished to beneficiaries.*

We absolutely support audits for those reasons. We simply ask that they also be fair and transparent. We are not asking for protection against any pharmacy that commits fraud. If a pharmacy is committing fraud we fully support that the Department of Social Services take appropriate action.

I would like to focus my testimony on two areas: the impact of clerical error extrapolation on small businesses and the compliance education offered by the Department to pharmacists.

Have you stepped into a pharmacy lately for a prescription? Pharmacies are a busy place. We are different from other providers in that we operate in a real time environment. What does that mean? You don't get your medication until we have jumped through all the hoops established by every third party payer – including the State of Connecticut. Although our primary focus as a health care provider is to ensure you are getting the right drug at the right dose for the right disease and that it is safe for you to take; we spend much of our time also ensuring that we comply with all the mandates of various third party payers. For example it may be the right drug but it is not on the plan formulary so we have to contact the doctor to change that or get a prior authorization. All of these processes take time and they have to occur so that the label we have to affix to your bottle will print out. It is all real time.

Pharmacies are also required by DSS to enforce many of their mandates on other providers. Let's take for example a costly audit finding in most pharmacies - the tamper-resistant prescription pads that prescribers must use to write prescriptions for controlled substances for Medicaid patients. Pharmacists need to enforce this mandate for the state by ensuring that these prescriptions – the actual paper - meet certain criteria. If all the criteria are not met, and it becomes part of an audit finding, the pharmacy is penalized by losing the **entire cost of the drug plus the dispensing fee.** Even after validation that the prescriber wrote for that medication and the patient received the medication, the pharmacy still loses the entire allowance because the *prescriber* did not follow the rules.

My question to the committee is does the penalty fit the crime? In a real business environment, pharmacies might be actually reimbursed to enforce the rule for DSS. Instead we are penalized. I would agree that the state might be justified in penalizing the pharmacy for total reimbursement if there was an established pattern of total disregard for this mandate by the pharmacy. However, if it is an isolated instance or it happens very infrequently, does this entitle the department to disallow the total cost of the drug....even when the patient did receive it and there is no evidence of fraud?

Does the penalty fit the crime?

Then adding insult to injury, the department uses these infrequent occurrences and extrapolates the losses across a total universe of claims to come up with an astronomical dollar amount the pharmacy must pay.

Attached to my testimony is an actual report from one of my small independent pharmacy owners who underwent an audit this past fall. You should consider this pharmacy to be a low to moderate Medicaid pharmacy.

The report basically states that the universe of claims in the three year audit period was 9,530 prescriptions. The state audited 100 prescriptions. Of these 100 claims they found 14 issues varying from a tamper resistant prescription to a couple where there was a missing diagnosis code for a drug and then some discrepancies in billing for compounded prescriptions. The actual disallowance for these errors – *and none of them suspicious of fraud* - was \$1,748. The state then took this amount and divided it by the 100 prescriptions they audited to come up with \$17.48 as an average error rate.

When the state then extrapolated this amount across the total universe of claims, ($\$17.4883 \times 9,530$) the pharmacy was sent a bill for \$166,663.00. Remember, this is a small independent pharmacy that does not do a lot of Medicaid. Imagine what that number becomes in pharmacies that are primarily Medicaid who are doing the best they can in a busy environment. This doesn't even take into account the expense that many pharmacies undertake with respect to the time it takes to gather the information and hiring lawyers. Let alone the stress levels when the audit drags out over a couple of years.

In another example where a pharmacy was audited: the universe of claims was about 73,000. They audited 100 prescriptions and found 28 issues. The first bill sent to the pharmacy was \$1.566 million dollars. After reviewing the errors, it was adjusted to \$197,000. Still, that is a lot of prescriptions needed to fill to pay for that assessment. Many pharmacies have to take out loans.

Pharmacies are penalized for **total disallowance of reimbursement** for many clerical errors which increases the "error rate" used in extrapolation. If there is a missing diagnosis code for the dozen or so prescriptions that are required to have one by the department the pharmacy loses total drug cost. If the pharmacy uses an incorrect NPI number, they lose the entire allowable amount. I can go into other items but our main question continues to be: If there is **no pattern** that would suggest a total disregard for the rules or fraud, should there be an allowance or adjustment given to minimize the amount the pharmacy should incur as an extrapolated fine?

We also believe that the audits have truly become punitive in nature. Instead of educating the provider on how to be compliant with the law, the pharmacists, on the front line, are immediately punished. CPA provides educational opportunities to pharmacists throughout the year. As a matter of fact we asked that one of the DSS pharmacy auditors come and speak at our conference we had last week for more than 200 pharmacists. The request was denied by the department because they plan to conduct education in the future.

I do have to applaud the Department on their recent outreach to us regarding the newly posted pharmacy protocols. The community pharmacy industry has reviewed the protocols and is asking for further discussion regarding several of the items. That date has not yet been set.

Is Connecticut a business friendly state? While we as taxpayers applaud some recent gains and what we hope to be a flourishing bio-science zone with Jackson Labs, I would have to frankly tell you that the business climate for pharmacies has not been as bright. I have explained to you some of the nuance issues we have with how audits are currently conducted. Can you imagine if other small businesses were routinely audited by the state and made to pay hundreds of thousands of dollars in fines?

Again, I want to be clear - we are not here to just complain about the process. We simply hope that some of our questions will provide pragmatic solutions that can be spelled out in legislation. Our goal is to work together to develop a fair process that encourages remediation and having successful audits.

The bottom line is this - If there has been no financial harm to the state from the federal government, there should be minimal financial harm to the provider of the service.

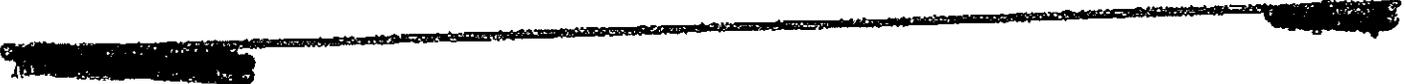
We would be very interested in working with the Committee to establish an audit bill that is fair to our pharmacies, and which provides fair and transparent language for all parties to follow.

Exhibit II

Schedule of Extrapolated Error Amount-T19



<i>Paid Claim Universe</i>	9530
<i>Sample Size</i>	100
<i>Total # of Overpayments in Sample</i>	14
<i>Total # of Underpayments in Sample</i>	0
<i>Total # of Errors in Sample</i>	14
<i>Total Sample Error Dollars</i>	\$1,748.83
<i>Average Dollar per Selected Claim</i>	\$17.4883
<i>Extrapolated Error Amount</i>	\$166,663



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.