



February 11, 2015

HB 6550, AAC Medicaid Provider Audits

Senator Moore, Representative Abercrombie and members of the Human Services Committee. My name is David Benoit, a pharmacist, and Vice-President of Northeast Pharmacy Service Corporation, a group purchasing organization for 111 Connecticut independent community pharmacies. I offer comments for consideration and in support of HB 6550, An Act Concerning Medicaid Provider Audits.

We believe that Connecticut independent pharmacies work diligently to timely and accurately provide medications to the Department of Social Services' (DSS) clients according to the Department's rules and regulations. As you know, there have been severe reimbursement cuts for prescription drugs in the last few years. At the same time, there have been some staggering audit findings, so large that they are unthinkable and that actually threaten the viability of the businesses providing services on behalf of the state.

Many findings are simple clerical and administrative errors that have nothing at all to do with fraud or willful deceit. Incorrect prescriber identification numbers, wrong street number, incorrect prescription origin code or inaccurate days' supply – these are errors that should be corrected, not recovered. In the Medicare D plans overseen by the Centers for Medicare and Medicaid Services, these types of errors are corrected not recovered.

The extrapolation from 100 pharmacy claims to tens of thousands or even hundreds of thousands of claims in a three year period is a flawed methodology. Extrapolation requires that the sample be likely to represent the average of all claims. Besides the size of the sample as an issue, it is not appropriate to exclude certain claims (like \$0 paid claims). All claims must have an equal chance of being part of the sample. Otherwise, the claim selection isn't random and not really representative of all claims.

When extrapolation is warranted it should be limited to like claims. For instance, if a non-conforming written prescription blank is found, findings should only be applied to other written prescriptions. These same errors cannot be found in faxed, oral, transferred or electronic prescriptions.

What we have been speaking to is the recovery of the whole prescriptions; what the state paid for the medication and the pharmacy dispensing fee. In all of the recovery circumstances we have seen, the patient got the medication on the original prescription and on all of the allowed

refills. Serious evaluation needs to be given to circumstances in which it would seem appropriate to recover only the dispensing fee.

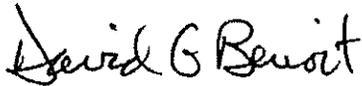
There is no question that audits are necessary to ensure the appropriate payments for provider claims billed to DSS. Audits can help prevent and detect fraud. Provider education by DSS should be a first line to ensure that claims are filled and billed properly. When providers are working with DSS to assure compliance, errors that have no intent to circumvent the rules should not be punishable in the extreme.

Audit recoveries against pharmacy claims are a hidden reduction to the razor sharp prescription drug reimbursements that have been approved by the legislature in the budget. Audit recoveries against pharmacy claims are not justly considered income.

We hope the passage of HB 6550 will lead to greater provider collaboration with DSS and fair and reasonable audit practices designed to secure compliance with the Department's intent, responsibilities, and obligations.

Northeast Pharmacy Service Corporation has worked with other providers in the Industry Collaborative to draft comprehensive audit concerns. The Draft is attached for your convenience.

Respectfully submitted,

A handwritten signature in black ink that reads "David G Benoit". The signature is written in a cursive style with a large initial "D".

David G. Benoit, MHP, RPh
VP, Patient Care Services
Northeast Pharmacy Service Corporation
Framingham, Massachusetts

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.

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.