HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 413 w/CS Medicaid Audits of Pharmacies/Pharmacists
SPONSOR(S): Brown and others
TIED BILLS: None. **IDEN./SIM. BILLS:** HB 1281 (s), SB 1428 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Services (Sub)	11 Y, 0 N	Mitchell	Collins
2) Health Care	21 Y, 0 N w/CS	Mitchell	Collins
3) Health Appropriations (Sub)	13 Y, 0 N w/1 Amd	Speir	Massengale
4) Appropriations			
5)			

SUMMARY ANALYSIS

HB 413 w/CS addresses alleged abuses against pharmacies and pharmacists by auditors contracted with the Agency for Health Care Administration (AHCA) to reduce Medicaid costs by recouping funds from pharmacies.

Pharmacists report that because of aggressive tactics by the contracted auditors, they were not given enough time to ensure adequate documentation was available to address or correct clerical errors. HB 413 w/CS addresses these problems by providing additional requirements for Medicaid audits of pharmacies. They include:

- At least one week prior notice of an audit.
- Qualifications of auditors.
- Requirements that certain errors do not constitute a willful violation and are not subject to criminal penalties without proof of intent to commit fraud.
- Use of the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record.
- A prohibition on the use of sampling and projections to a population in determining an overpayment.
- Requirements that all pharmacies be audited under the same standards and parameters.
- Allowing a pharmacist at least ten days in which to produce documentation to address any discrepancy found during an audit.
- A limitation on the period covered by an audit to one calendar year.
- A prohibition on an audit being scheduled during the first five days of any month;
- A requirement for delivery of a preliminary audit report to a pharmacist within 90 days after conclusion of the audit, with a final audit report delivered within six months of the preliminary report.
- A process for a preliminary review of an audit report by peers.
- A requirement for dismissal of an audit if the peer review panel finds that the pharmacist did not commit intentional fraud.

The requirements of the bill do not apply to investigative audits conducted by the Medicaid Fraud Control Unit of the Department of Legal Affairs.

The Agency for Health Care Administration reports the fiscal impact is indeterminate. Without the authority to extrapolate findings from a sample, however, audits will recover fewer funds that can be used to reduce Medicaid costs.

The bill takes effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a “no” above, please explain:

B. EFFECT OF PROPOSED CHANGES:

Background

Pursuant to section 409.913(2), F.S., the Agency for Health Care Administration is required to conduct audits or contract with a vendor to conduct audits. The agency contracted with Heritage Information Systems, Inc. (Heritage) to conduct compliance audits of pharmacy providers, between November 1999 and October 31, 2002, as part of an aggressive auditing program designed to weed out fraud, abuse and waste in the Medicaid prescribed drug therapy program and reduce costs to the state. The auditing efforts included a review of prescription records to compare them with claims information. If there was a discrepancy such as three refills on a prescription number with only one refill noted on the hard copy prescription, the Medicaid Program classified the two extra refills as improperly paid and required recoupment by the pharmacy provider.

Because auditors only look at a sample of prescription claims, they use an accounting method called “extrapolation” to project from a random sample of claims reviewed the entire Medicaid business of the pharmacy provider. This means that because of possible clerical errors in recordkeeping, the pharmacy may be penalized not only for the improper claim but a percentage of all claims filed for a defined period of time.

According to AHCA, as of August 30, 2002, a total of $9,047,065 was identified from the sample claims reviewed. This included judgmental and statistical samples of $7,969,726 and $1,077,338, respectively. With extrapolation, a total of $42,933,529 was identified as overpayments. This included $7,969,726.89 from the judgmental sample and $34,963,802.84 projected from the statistical sample to the population. The Medicaid Program spent approximately $3 billion for prescribed medicines for the two-year period ending June 30, 2002. This $42.9 million in identified overpayments represents approximately 1.4 percent of expenditures for prescribed medicines.

The most common problem found is failure to find original prescriptions or failure to adequately document refill authorizations. According to pharmacist representatives, there is nothing "fair" about recouping money paid to pharmacies in cases in which AHCA received what it bargained for—medicine dispensed to poor people.

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. Under s. 409.902, F.S., the Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The Florida Medicaid Program spends more

than $12 billion annually providing health care. The proportion of annual health care expenditures lost to fraud and abuse remains unknown because these losses are not systematically measured.

Sections 409.913 and 409.9131, F.S., prescribe the activities of the agency related to oversight of the integrity of the Medicaid Program. Staff of the Medicaid Program Integrity Office develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate recovery of overpayments in instances of provider abuse, and recommend administrative sanctions for providers who have abused or defrauded Medicaid.

The Medicaid Overpayment Recovery Processes

Overpayments by Medicaid are often lumped into the generic category of "Medicaid fraud," however, Medicaid fraud is a subset of the larger category of "Medicaid overpayments." Medicaid overpayments may result from a host of problems, including provider billing errors, confusion about Medicaid policy requirements, poor medical practice, poor business practices, or fraud. If an overpayment is the result of an intentional action on the part of the provider, in order to gain an unauthorized benefit, it becomes "fraud."

Although the Medicaid Program Integrity (MPI) Office within AHCA searches for, identifies, and investigates overpayments, MPI does not investigate, prosecute or recover in the case of fraud. If MPI staff, in their investigation, suspect that the provider's billings are based on intentional fraud, MPI staff are required by federal and state law to refer the case to the Medicaid Fraud Control Unit (MFCU) in the Department of Legal Affairs under the Attorney General.

Medicaid Program Integrity finds its cases via peer review organization audits, referrals from Medicaid policy staff, reports from other providers, as well as reports from Medicaid recipients. MPI uses a variety of data mining techniques to identify suspicious provider billing patterns. Once a suspicious billing pattern is identified, MPI reviews the provider's records to determine if the provider's payment was inappropriate. Using statistical methodologies such as sampling to determine error rates and then applying error rates to a provider's universe of claims, MPI computes an amount that it believes the provider has been overpaid and sends the provider a "preliminary audit letter" (PAL).

The provider is allowed to dispute the findings in the PAL by submitting additional information, such as additional documentation that a service was actually rendered or was medically necessary. After considering the information the provider has submitted, MPI makes its final determination of the actual Medicaid overpayment and sends the provider a "final audit letter" (FAL), which is the agency's determination of the amount due to and collectible by Medicaid. If the provider feels the agency is incorrect in this determination, the provider has a right to appeal the decision to the Division of Administrative Hearings (DOAH).

Medicaid Pharmacy Audits

Section 409.913(2), F.S., requires the agency to conduct, or cause to be conducted audits to determine possible fraud or abuse in the Medicaid Program. The agency contracted with Heritage Information Systems, Inc., between November 1999 and October 31, 2002, to conduct compliance audits of pharmacy providers. Heritage currently performs two types of on-site audits: a one-day audit referred to as an "on-site audit" and a multi-day audit referred to as an "in-depth" audit.

In an **on-site audit**, the provider is given approximately one week prior notice and the audit lasts one day. In this audit a statistically valid random sample of paid claims are generated from the Medicaid paid claims file. The supporting documentation of each claim is reviewed at the pharmacy for compliance. During the audit and upon completion of the review, the provider is informed of the discrepancies found and is given the opportunity to address those issues and provide five additional

days to submit additional documentation. Overpayments found in the sample are extended to the population of claims using a statistical methodology and an overpayment for the audit is determined.

In-depth audits, lasting four to five days, are ordered when, based on a preliminary review, the agency believes that a more thorough analysis is required and it is believed that providing notice may compromise the effectiveness of the audit. Therefore, the provider is not given notice for this type of audit. This audit consists of the review of a random sample of claims and the results are extended to the population of claims being reviewed to identify the overpayment for this review. This audit also compares purchase documentation for approximately 20 drugs with claims paid by Medicaid. An overpayment for this review is computed for any purchase shortages. The provider must address both overpayments.

Common Violations

The most common violations found in the review of the prescription records were:

- Cannot find an original hard copy prescription document.
- Failure to document additional refills.
- Wrong prescriber on claim.
- Over billed quantity.

Medicaid record requirements are more extensive than those of normal business practices. Medicaid requires that the original prescription or physician's order must be maintained in its original paper form or as an exact front and back scanned image of the original prescription or physician's order. The original prescription or physician's order paper document is required to be physically filed, stored, readily retrievable, and furnished as needed or requested. The existence of or storing of data regarding the original prescription, physician's order, or dispensing information in a computer database or reports generated is not sufficient for compliance.

Additional refill authorization must be documented by either creating a new original prescription, or adding the additional authorized refills to the original prescription or physician's order by noting at least the date, number of additional refills, and the prescriber or prescriber's agent authorizing the refills. This notation must be retained on the original prescription document (paper form) or in the computer database and readily retrievable. Adding additional refills without documenting the above information is not sufficient for compliance.

In addressing alleged abuses against pharmacies and pharmacists by auditors, HB 413 includes the following provisions:

- Requires the agency to provide at least one week prior notice of an audit.
- Requires that an audit must be conducted by a pharmacist licensed in this state.
- Provides that certain errors (any clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error) do not constitute a willful violation and are not subject to criminal penalties without proof of intent to commit fraud.
- Allows a pharmacist to use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend drug or narcotic drug.
- Prohibits the use of sampling and projection of results to the population in determining the overpayment.
- Requires that all pharmacies be audited under the same standards and parameters;
- Provides that a pharmacist must be allowed at least ten days in which to produce documentation to address any discrepancy found during an audit.
- Limits the period covered by an audit to one calendar year.
- Prohibits an audit from being scheduled during the first five days of any month.

- Requires that a preliminary audit report must be delivered to the pharmacist within 90 days after conclusion of the audit and a final audit report be delivered within six months of the preliminary report.

The bill requires AHCA to establish a process by which a pharmacist may obtain a preliminary review of an audit report and may appeal an unfavorable audit report without the necessity of obtaining legal counsel. The preliminary review and appeal may be conducted by an ad hoc peer-review panel appointed by the agency, consisting of pharmacists in active practice. The bill requires the agency to dismiss the audit report without the necessity of any further proceedings if the peer review panel finds that the pharmacist did not commit intentional fraud.

C. SECTION DIRECTORY:

Section 1. Creates an undesignated section of law establishing standards for Medicaid audits for pharmacies.

Section 2. Provides the act shall take effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The Agency for Health Care Administration reports the fiscal impact is indeterminate. Without the authority to extrapolate findings from a sample, audits will recover fewer funds that can be used to reduce Medicaid costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would reduce recoupment of Medicaid funds from pharmacies on what may be sampling and clerical errors and permit pharmacies to address record problems, without losing income and having to seek legal recourse to defend themselves.

D. FISCAL COMMENTS:

Federal regulations require that states recover overpayments to providers, regardless of whether the overpayment was the result of fraud or simply the result of an error. The requirement in the bill that the state dismiss audit reports in which intentional fraud was not committed will place Florida out of federal compliance in the administration of its Medicaid Program, which could jeopardize federal financial participation.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

The Agency for Health Care Administration reports that this bill may generate litigation by non-pharmacy providers against AHCA on constitutional grounds relating to “equal protection” concerns.

B. RULE-MAKING AUTHORITY:

The bill authorizes the agency to establish a procedure for certain activities, but does not provide specific rulemaking authority to do so.

C. DRAFTING ISSUES OR OTHER COMMENTS:

It is recommended by AHCA that the notice required to be given to a pharmacist be reduced from two weeks to one week.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 12, 2003, the Health Services Subcommittee adopted two amendments:

Amendment 1 is a technical amendment to clarify wording with regard to provisions of the bill applying only to Medicaid-related audits of a pharmacy. The provisions of the bill do not apply to other financial or fraud control audits of pharmacies.

Amendment 2 removes redundant wording that explicitly included community, institutional and special pharmacies in the bill, when reference only to pharmacies is sufficient.

On March 19, 2003, the Health Care Committee adopted two amendments:

Amendment 1 changes the period for advance notice of an audit from two weeks to one week.

Amendment 2 changes the period for delivery of the audit report to delivery of a preliminary audit report within 90 days and a final audit report within six months of receipt of the preliminary report.

The four amendments were adopted by the Health Care Committee and the bill was reported favorably with a Committee Substitute.

On April 21, 2003, the Subcommittee on Health Appropriations adopted one amendment, which clarifies when preliminary unfavorable audits may be dismissed by the Agency for Health Care.