SENATE BILL REPORT
ESHB 1737

As of March 22, 2011

Title: An act relating to the department of social and health services' audit program for pharmacy payments.

Brief Description: Concerning the department of social and health services' audit program for pharmacy payments.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Short, Seaquist and Schmick).

Brief History: Passed House: 3/04/11, 96-0.
Committee Activity: Health & Long-Term Care: 3/21/11.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: State medical assistance programs pay for health care for low-income state residents, primarily through the Medicaid program. These programs are administered by the Department of Social and Health Services (DSHS). DSHS is authorized in statute to conduct audits and investigations of providers of health services to beneficiaries under the state medical assistance programs that it administers. To discover the provider's usual or customary charges, DSHS may examine random representative records as necessary to show accounts billed and received. If an overpayment is discovered, it may be offset by underpayments also discovered in the same audit sample. If an audit shows an overpayment, DSHS must give notice to the provider demanding that the overpayment be paid within 20 days. The provider may request a hearing if the request is filed within 28 days of the notice.

Additional provisions for audits are outlined in DSHS rules. Providers must enter into agreements with the DSHS to be approved as a provider. They must keep legible, accurate, and complete records to justify the services for which payment is claimed. Records must be available for six years from the date of service, unless state or federal law requires a longer period. Audits may be conducted either on-site, by a desk audit, or a combination of the two. Providers are to be given ten days advance notice of an on-site audit. They may be performed on a per-claim basis or by using a probability sample. If a sample is used, it must meet recognized and generally accepted sampling methods and must ensure a minimum 95 percent confidence level when projecting an overpayment.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

On completion of an audit, the provider has 30 days to locate and provide any missing records. After the 30-day period, a draft audit report is issued. Within 30 days, unless the time is extended, the provider may comment on the draft audit report or submit additional information. A dispute conference may also be requested. A final audit report may be appealed as provided by law.

Federal law requires each state administering a Medicaid program to establish and maintain an adequate internal control structure to ensure that Medicaid is administered in compliance with federal law. This control structure must be part of the approved state plan required to receive federal funding. Various government audit requirements establish the standards that the state must meet, including ensuring the propriety of expenditures reported for federal matching funds. State auditors also review Medicaid expenditures annually under the federal Single Audit Act of 1984. States must ensure both proper payment and recovery of overpayments for unallowable claims.

Summary of Bill: Audits of pharmacy records performed by DSHS under its administration of the medical care services programs must meet certain standards related to notice of an audit, supplemental documentation, and audit findings.

- Initial audits may not begin earlier than 30 days prior to the date that notice of the audit was provided to the pharmacy. Audit results that violate this may not be used in any audit findings.
- An audited pharmacy may use the written records of a hospital, physician, or other pharmacy to validate its records. An audited pharmacy must have at least 90 days from the delivery of the draft audit findings to respond with additional documentation.
- A finding of overpayment may not be based upon technical deficiencies if the pharmacy can demonstrate through documentation that the claim meets the definition of an allowable cost. A technical deficiency is a billing error or omission that does not affect any element of an allowable cost. Technical deficiencies do not include failure to routinely obtain prior authorization; failure to properly document expedited prior authorization; or fraud, patterns of abusive billing or noncompliance, continuous violations, or gross or flagrant violations. An allowable cost is a medical cost that is covered by the state's Medicaid plan, supported by medical records as having been provided and being consistent with the medical diagnosis, is properly coded, and is paid at the allowed rate. In determining whether or not the pharmacy has provided adequate records to indicate that services were consistent with a medical diagnosis, DSHS must consider the record according to that which a reasonable pharmacy would be expected to maintain.

The act applies retroactively to audits that DSHS began on or after April 1, 2011.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: There are concerns with the subjective audit practices of DSHS. There needs to be sideboard for which records are required and exceptions for technical deficiencies. Prescribers are not required to provide the diagnosis on every script but pharmacies may be required to provide the records. Audits are concerning. Pharmacies provide medications and may then have a retrospective audit that results in the drugs not being paid for. The pharmacies are a retail business and are different from other provider types in our need to maintain an inventory. The old billing system was a particular concern; and some audits are still covering claims submitted under the old billing system, prior to implementation of Provider One. Even Provider One claims are complex, and it is difficult to keep up with the changes so we believe technical deficiencies in submitting claims should not be an audit finding. An audit can result in review of numerous claims with extensive paper documentation requirements. Audit resources should be focused on finding true abuses and not on misunderstanding the law or rules.

CON: We've provided a detailed letter that explains our concerns, but in brief our two major concerns are with the language that contradicts the federal requirements. The new floor amendment adds a standard for what a reasonable pharmacy would keep records of but this eliminates a clear defined criteria for review. The confusion will just lead to increased requests for administrative hearings to defend what a reasonable pharmacy would maintain. The billing instructions indicate which records need to include a diagnosis – only for selected drugs in an expedited review. Our second major concern is with establishing a different set of audit standards just for pharmacies – the audit standards right now apply to all provider types, and establishing a different standard may open up an equal protection challenge. Adding the language regarding technical deficiencies may create a problem because the federal audit teams will not recognize that standard and could require a recovery that could leave the state at risk in returning money we can not recover.

Persons Testifying: PRO: Representative Short, prime sponsor; Jeff Rochon, Dedi Hitchens, Washington State Pharmacy Association; Julie Akers, The Everett Clinic; Lis Houchen, National Association of Chain Drug Stores; Washington Food Industry.

CON: Cathie Ott, DSHS, Medicaid Purchasing Administration.