F I S C A L I M P A C T R E P O R T

SPONSOR SCORC **ORIGINAL DATE** 2/19/19 **LAST UPDATED** 3/3/19 **HB**

SHORT TITLE Pharmacy Audit Changes and Exceptions **SB** CS/394/aSJC

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		See Fiscal Implications Below				

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Retiree Health Care Authority (RHCA)
Regulation and Licensing Department (RLD)
Human Services Department (HSD)

SUMMARY

Synopsis of SJC Amendment

The Senate Judiciary Committee amendment to the Senate Coporations and Transportation Committee Substitute for Senate Bill 394 makes the following changes:

- It limits pharmacies to 21 business days to resubmit a claim denied by an insurer as a result of an audit, as long as proper prescription documentation has occurred and the claim is used in place of recoupment of a claim where the patient has not suffered financial harm,
- It makes clear that recoupment of a claim of a pharmacy by an insurer for an unpaid patient co-payment cannot be made if the pharmacy documents billing for the co-payment and a reasonable attempt to collect it; and
- It removes the prohibition of contract language (between insurers or pharmacy benefit managers on the one hand, and pharmacies, on the other hand) that abrogate the provisions of this act.

Synopsis of Bill

Senate Corporations and Transportation Committee Substitute to Senate Bill 394 makes a

number of changes to Section 61-11-18.2 NMSA 1978 (entitled Audit of Pharmacy Records). The changes include adding pharmacy benefit managers (PBMs) and their subcontractors to the list of entities that will perform audits, and specifies conditions and limits to audit procedures. New provisions in this bill affect the section in statute in the following ways:

- Audit results can only be used to recoup payments to pharmacies if they have resulted in financial harm.
- A finding of overpayment may be based only on demonstrated actual overpayment, not on a projection from limited data, as has been previously possible, and recoupment is limited to the amount overpaid to the pharmacy.
- The audit period remains at two years.
- The auditing entity cannot profit from the results of the audit.
- The entity performing the audit cannot charge for having done the audit unless fraud is found
- A pharmacy may resubmit a claim to correct clerical errors as a result of an audit finding.
- Requirements for valid prescriptions or a pharmacy benefit manager's operational standards cannot be more stringent than federal or state standards and can be satisfied by placing additional information on the prescription or placing the material on the patient's electronic profile, with notice to the prescriber.
- Number of units of prescriptions such as drops, topicals and inhalants cannot be limited beyond manufacturers' recommendations.
- Amount of prescription dispensed can be no smaller than the package size available.
- If a pharmacy has billed a patient for a copayment, the amount of copayment not collected cannot be subtracted from the pharmacy's reimbursement.
- Investigative audits into probable or potential fraud, waste, abuse or willful misrepresentation would not be subject to the above restrictions.

Entities conducted an audit cannot audit another such entity; their results must be based on specified evidence obtained through the pharmacy or through the pharmacy's suppliers, if that evidence is provided to the pharmacy within five days.

Contracts between entities, including pharmacy benefit managers, insurance companies, third-party payors, could not include clauses nullifying the provisions of this act (this provision was removed by the amendment)..

FISCAL IMPLICATIONS

No fiscal impacts of the bill itself are identified, although HSD indicates that the bill's provisions might conflict with federal requirements, which could have the major impact through denial of the federal Medicaid match.

SIGNIFICANT ISSUES

There are of course conflicting views on pharmacy audits' problems and benefits. Two representative views are attached. Among other states that have passed legislation to regulate the performance of pharmacy audits, the Texas legislature passed HB 1358 in 2018, enacting many of the changes brought forward in this bill.

HSD comments as follows regarding its role in managing the state's Medicaid program and its requirements to assure absence of fraud and abuse in the program:

> As a participant in the Medicaid program, New Mexico is required by federal regulations to establish program integrity requirements (Title XIX of the Social Security Act, Section 1936 and the New Mexico State Medicaid Plan). Failure by the state to properly safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments consistent with federal law and regulation could potentially jeopardize federal Medicaid matching funds. This bill proposes a significant change in the way the Human Services Department (HSD) oversees managed care organizations (MCOs), particularly with respect to the processes for determining credible allegations of fraud and the identification and recoupment of overpayments (Title 42 CFR 455).
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> Section (F) of SB394 redefines "entity" as a managed care company, insurance company or third-party payor, or representative of a managed care company, insurance company or third-party payor, or a pharmacy benefits manager or a subcontractor of a pharmacy benefits manager. The definition includes "managed care company" and is a term synonymous with MCO. HSD contracts with MCOs to assist in the oversight of providers, to include pharmacies. Including MCO in the definition of an entity would be inconsistent with and could impact the state's ability to protect Medicaid funding through the use of MCOs.
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> Section (A)(5) of SB394 strikes the language stating "[unless the entity demonstrates a statistically justifiable method of projection or the projection for overpayment or underpayment is part of a settlement as agreed to by the pharmacy]". Projection is synonymous with extrapolation. The limitation on extrapolation of claims would be financially and logistically burdensome for the MCOs and thus the state. This prohibition is also inconsistent with federal guidelines issued by the Centers for Medicare and Medicaid Services (CMS - Medicaid Program Integrity Manual Issued February 2, 2018). Medicaid overpayments, whether they be attributable to fraud or abuse or created by other circumstances, contain a federal Medicaid matching portion. CMS is entitled to its proportionate share of settlement or final judgment amount on overpayments. In view of the enormous logistical problems of Medicaid enforcement, courts have found that statistical sampling is the only feasible method available to determine an overpayment (Illinois Physicians Union v. Miller, 675 F.2d 151 (7th Cir. 1982) (Medicaid); Michigan Dept. of Educ. V. United States, 875 F.2d 1196 (6th Cir. 1989) (vocational rehabilitation programs); and Ratanasen v. Cal. Dept. of Health Servs., 11 F.3d 1467 (9th Cir. 1993). A 5% error is sufficient for extrapolation and is accepted by the U.S. Department of Health and Human Services (DHHS), according to Dr. Alan Kvanli, a statistical expert who has worked with DHHS and CMS on sampling and extrapolation. Claim universes in such cases can run into the tens of thousands. Requiring a claim-by-claim review in cases where the error rate was as high as 10% would render such a review by a MCO practically impossible. HSD depends on MCOs to conduct audits using extrapolation.
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> Section 12 of SB394 adds language that a person performing an on-site or a desk audit shall not directly or indirectly receive compensation based on the result of the audit. The Act defines a "person" as an individual, corporation, partnership, association or other legal entity. This limitation would conflict with federal regulation and the State Medicaid Plan that requires the state to conduct compensation-based provider audits, to include

pharmacies, through the use of a Recovery Audit Contractor (RAC) (Title XIX of the Social Security Act, Section 1902 and the State Medicaid Plan). HSD contracts with the RAC directly, as required under federal regulation.

Section 13 of SB394 adds language that an entity shall not charge a fee for conducting an on-site or a desk audit unless there is a finding of actual fraud. This limitation would conflict with federal regulation and the State Medicaid Plan, which requires the state to conduct fee-based provider audits, to include pharmacies, through the use of MCOs and regardless of whether fraud is found or not (Title XIX of the Social Security Act, Section 1903 and the State Medicaid Plan).

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