

The Three Most Misunderstood Words in Health Care: Fraud, Waste and Abuse

by **Susan A. Hayes, D.Crim.J.** | *Pharmacy Investigators and Consultants*

When reading the words “fraud, waste and abuse in health care,” many people likely think of shady physicians upcoding claims for services they never rendered followed by a massive bust by the Department of Justice or FBI. Like all professionals, physicians, nurses and pharmacists can be charged with committing fraud. In September 2021, 138 defendants—including 42 doctors, nurses and other licensed medical professionals—in 31 federal districts across the United States were arrested for their alleged participation in various health care fraud schemes that resulted in approximately \$1.4 billion in alleged losses (Department of Justice website, 2021). These kinds of schemes would make for a great television series, like *The Pharmacist* true crime series on Netflix.

But waste is an even bigger problem that does not make for great binge-worthy television shows. And it’s a problem that has been exacerbated by the pandemic.

What Is Waste?

To understand waste in prescription drugs, it’s important to first understand how a pharmacy claim is processed.

In 2001, the National Association of Chain Drug Stores and the National Community Pharmacists Association, together with the leading three pharmacy benefit managers (PBMs)—OptumRx, Express Scripts, Inc. and CVS/Care-

AT A GLANCE

- Employers that sponsor health plans need to be aggressive in directing pharmacy chains and independents to not allow medication autorefills and autofills, since unlike with Medicare and Medicaid, there are no laws prohibiting this practice for commercial plans.
- Plan sponsors can also require an aggressive pharmacy benefit manager (PBM) fraud, waste and abuse (FWA) program that includes requiring patient signatures for every prescription dispensed, with reporting to plan sponsors the results of this program.
- Employers should insist that PBMs put programs in place to prevent medication from being “recycled” within the pharmacy, as pharmacies outright not reversing claims is fraud, particularly if that medication is bought a second time.

mark—formed an alliance called SureScripts (SureScripts, 2022). This alliance allowed prescription drug orders to be sent electronically from a patient's electronic medical record (EMR) to the pharmacy. Patients no longer had to take handwritten prescriptions to the pharmacy, wait for the prescription to be filled and then go home to take the medication.

According to the 2021 SureScripts *National Progress Report*, 35 states—including New York, California and Florida—representing 75% of all U.S. residents, now require all prescriptions to be prescribed electronically. The remaining 23 states and territories have pending or enacted legislation. In the next few years, all prescriptions will likely be processed electronically since 99% of all people in the U.S. are represented in the SureScripts database (SureScripts, 2021 *National Progress Report*, p. 2).

When a prescription is sent from a patient's EMR to the pharmacy, the pharmacy immediately begins the adjudication process. This means that the claim is electronically sent to the patient's PBM, which prices the claim and checks for eligibility for both the patient and the drug. Any other requirement, like a prior authorization, is checked by pharmacy personnel. Documentation is retained by the pharmacy—No actual documents are sent to the PBM.

Electronic claims processing has achieved the following:

- Reduced the median wait time for a prior authorization decision by more than two-thirds, from 18.7 to 5.7 hours
- Made it easier to understand whether prior authorization was required for 60% of users
- Improved timeliness of care for 71% of users.

PBMs and health plans representing 98% of insured patients are contracted by SureScripts for electronic prior authorization. Because less time is being spent on prior authorization, critics have questioned whether this has come at the cost of meaningful clinical counseling between patients and providers to ensure medical necessity. Prior authorizations may not be receiving thorough and proper clinical oversight or a complete medical necessity determination. This really is the first stop is understanding how waste occurs.

The next stop in understanding waste is the practice of autorefills and autofills. *Autorefills* are system-generated messages from the pharmacy to the prescriber asking for the pre-

scription to be refilled. In most states, the physician must see the patient annually to refill a prescription, but physicians—many of whom are overworked—will generally refill the prescription without seeing the patient, especially for chronic conditions. “This (autorefills) is a major flaw with pharmacy automation (and) is well-known to the industry. But there hasn’t been much movement to fix the problem,” states Michael Cohen, R.Ph., in a *Philadelphia Inquirer* article (Cohen, 2015). Unfortunately, rarely do patients or their doctors remember to communicate to the pharmacy a discontinuation of a prescription. And if the pharmacist doesn’t know about changes, the computer is not reset. “The auto-refill system just keeps rolling along, dispensing unneeded and possibly harmful medicines,” said Cohen.

Autofills are another problem. Autofills occur at regular intervals so that the patient's medication will never run out. Take the example of a physician who writes a prescription in January for a year's supply of a medication, refillable every 30 days. With autofills, when 75% of the prescription is consumed at day 22 for a 30-day fill, the pharmacy system generates the fill, a robocall is generated to the patient and the medication awaits the patient's return to the pharmacy. Particularly during the pandemic, some local chains were mailing the autofills to patients and automatically charging the copay to the patient's credit card on file and the balance of the cost to the plan sponsor. With autofills, at 22-day intervals, a prescription could be refilled 16 times with a whopping 497 days' supply within a 365-day period. An article in *Consumer Reports* (Gill, 2020) even told patients exactly how to get their medication autofilled (and switched to even greater and more wasteful 90-day supplies).

This system can generate waste because the patient may no longer need or want the medication.

Both autorefills and autofills are prohibited by Medicare Part D and Medicaid regulations unless they are approved by the patient. Retailers and PBMs have been hit with judgments and investigations over the use of these refill programs (Mazina, 2018) for Medicare and Medicaid patients.

If this avalanche of medications is not picked up in the pharmacy, what happens to them? Called *abandoned* or *unclaimed prescriptions*, these medications are typically returned to stock by pharmacy technicians. The cost to restock

and reverse these claims is about \$25 per prescription in time and materials (Doucette and Al-Jumaili, 2016). The workload for pharmacy technicians increased during the pandemic, as they were asked to take on additional details, including giving vaccination shots. But staffing levels did not increase, and many stores lost workers and struggled to fill positions. This may mean that return-to-stock duties, including the reversal of prescriptions, were relegated to the back burner by pharmacy technicians who just attempted to get through a shift at the pharmacy (Kaplan, 2021). Reversing the claim (and not just returning the medication to stock) is important because that is the step that takes the charge off the invoice submitted to plan sponsors by PBMs.

Lastly, many executive orders by governors suspended rules imposed by managed care to obtain patient signatures on prescriptions (Council of State Governments, 2021) in states such as Michigan, California and New Jersey. Many of these rules remain in place, although some are scheduled to expire in late 2022. Therefore, there was really no record in the pharmacy to substantiate whether a patient actually picked up medications, and auditors' hands were tied in attempting to ascertain whether patients did consent to autorefills or autofills or whether they requested and picked up the medication refills.

What Is the Impact?

With more prescriptions to fill than ever, no check of autorefill or autofill prescriptions in commercial plans, no one able to return medication to stock,

and no auditors able to enforce patient signature mandates, wasteful prescription drugs were dispensed. It is possible that many medications were adjudicated and paid for by one plan sponsor, then put back on the shelf only to be paid again by another plan sponsor (referred to as *recycled medications*).

Further, automation of the prior authorization process has yielded increases in specialty drug dispensing. Drug Channels Institute estimates that in 2020, retail, mail, long-term care and specialty pharmacies dispensed about \$176 billion in specialty pharmaceutical prescriptions (Fein, 2021). That's an increase of 9.1% from the 2019 figure. The top three dispensers of specialty medication are PBMs (CVS, Express Scripts and Prime Therapeutics). In 2020, overall pharmaceutical expenditures in the U.S. increased by 4.9% compared with 2019, for a total of \$535.3 billion. Utilization (a 2.9% increase) and new drugs (a 1.8% increase) drove this increase, with price changes having minimal influence (a 0.3% increase).

These increases in pharmacy spending occurred at the same time the American Medical Association was reporting a dramatic decrease in medical visits (American Medical Association, 2022). The Medicare Physician Fee Schedule (MPFS) spending dropped sharply in March and April of 2020, falling as much as 57% below expected levels. Although it recovered from the April low, MPFS spending in the fourth quarter of 2020 was still 10% less than expected. For all of 2020, the estimated reduction in Medicare physician spending associated with the pandemic was \$13.9 bil-

lion (a 14% decrease compared with the expected reduction). An estimated 39% of Medicare fee-for-service enrollees received a telehealth service in 2020, up from less than 1% in 2019.

In other words, even though patients went to their physicians much less frequently, drug spending increased along with the frequency of dispensing medications.

Plans had to foot the bill for this. The Society for Human Resource Management (SHRM) states that health plan premium cost increases are estimated to be around 5% in 2022 and back to prepandemic levels (Miller, 2021). Some consulting firms have projected the annual cost trend will be as high as 8.4%, mostly driven by price increases and new specialty drugs.

What Can Be Done to Reduce Waste in Pharmacy Spending?

One way to identify when patients pick up drugs would be for health plans to text members that a prescription has been paid for on their behalf. Members could then easily notify their plan if a prescription has been adjudicated but not requested by the patient. These texts would be similar to the ones sent by banks when customers make a payment, have an unusually high dollar charge or change their password. If the patient indicated that they did not order the prescription or never picked it up, the PBM could then reverse the claim. Plan sponsors may encounter some resistance to this system since it would reduce the number of prescriptions dispensed and therefore reduce revenue to the PBM.

Fully insured plans are at risk for the cost of prescription drugs and should also be interested in wasteful spending. However, many of these plans simply pass on the additional costs in higher premiums. Many insured plans also never provide plan sponsors with claims history, so plan sponsors do not know to ask members whether they received the medications (i.e., through an explanation of benefits or through texting).

Other challenges to this approach include laws that govern texting confidential protected health information (PHI) to members and dependents such as the Health Insurance Portability and Accountability Act (HIPAA) and the Telephone Consumer Protection Act. Further, plans have also not been proactive in obtaining up-to-date cell phone numbers for members, let alone spouses and dependents. This makes texting problematic for health plans (with multiple and underage dependents) as opposed to banking, where the relationship is between a single account owner and the bank.

Like Medicare and Medicaid programs, employer-sponsored plans should only allow PBMs to autorefill or auto-fill medication at the patients' request *and* prohibit this practice by pharmacies through network contracting. Pharmacy network contracts between PBMs and network pharmacies should strictly prohibit autorefills and autofills unless patients have authorized these programs on a prescription-by-prescription basis. It may be difficult to obtain this safeguard since both pharmacies and PBMs profit from these practices.

Another option is to directly contract with a separate non-PBM entity for fraud, waste and abuse auditing. This would provide employers with visibility of pharmacy practices.

Wasted Away Again

Considering the expense of medications, plan sponsors cannot afford waste in the prescription drug plan. U.S. Surgeon General C. Everett Koop famously stated in 1985 that "Drugs don't work in patients that don't take them." Sadly, drugs don't work in patients who don't take them, even if their employers are paying for them. Plan sponsors should take aggressive stances with PBMs, directing pharmacy chains and independents to not allow autorefills and autofills since, unlike with Medicare and Medicaid, there are no laws prohibiting this practice for commercial plans.

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Plan sponsors can also require their PBMs to have an aggressive fraud, waste and abuse program that includes requiring patient signatures for every prescription dispensed and reporting to plan sponsors the results of these programs. It is fraudulent for pharmacies to not reverse claims for unclaimed prescriptions, particularly if the medication is "bought" a second time. A flimsy fraud, waste and abuse program that looks the other way on such activity amounts is a fraudulent scheme.

It is doubtful that the next Netflix drama will be titled *Wasted Away Again in the Pharmacy*. But plan sponsors should realize the occurrence of "recycled" medication at pharmacies (paid for by two or three plan sponsors) and insist that their PBM put programs in place, such as fraud, waste and abuse monitoring programs and text verification. Plan sponsors should not be the losers by paying for wasted medication. 

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