

# SENATE BILL No. 1354

November 8, 2012, Introduced by Senators CASWELL and KAHN and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled  
"Public health code,"  
(MCL 333.1101 to 333.25211) by adding section 17775.

## THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1        SEC. 17775. (1) SUBJECT TO THIS SECTION, A HEALTH BENEFIT  
2        PAYER MAY CONDUCT AN AUDIT OF A PHARMACY IN THIS STATE. A HEALTH  
3        BENEFIT PAYER THAT CONDUCTS AN AUDIT OF A PHARMACY IN THIS STATE  
4        SHALL DO ALL OF THE FOLLOWING:

5        (A) IN ITS PHARMACY CONTRACT, IDENTIFY AND DESCRIBE IN DETAIL  
6        THE AUDIT PROCEDURES. A HEALTH BENEFIT PAYER SHALL UPDATE ITS  
7        PHARMACY CONTRACT AND COMMUNICATE ANY CHANGES TO THE PHARMACY AS  
8        CHANGES TO THE CONTRACT OCCUR.

9        (B) PROVIDE WRITTEN NOTICE TO THE PHARMACY AT LEAST 2 WEEKS  
10       BEFORE INITIATING AND SCHEDULING THE INITIAL ON-SITE AUDIT FOR EACH

1 AUDIT CYCLE. A HEALTH BENEFIT PAYER SHALL NOT INITIATE OR SCHEDULE  
2 AN ON-SITE AUDIT DURING THE FIRST 5 CALENDAR DAYS OF A MONTH,  
3 HOLIDAY TIME FRAMES, WEEKENDS, OR MONDAYS UNLESS OTHERWISE  
4 CONSENTED TO BY THE PHARMACIST. A HEALTH BENEFIT PAYER SHALL BE  
5 FLEXIBLE IN INITIATING AND SCHEDULING AN AUDIT AT A TIME THAT IS  
6 REASONABLY CONVENIENT TO THE PHARMACY AND THE HEALTH BENEFIT PAYER.

7 (C) UTILIZE EVERY EFFORT TO MINIMIZE INCONVENIENCE AND  
8 DISRUPTION TO PHARMACY OPERATIONS DURING THE AUDIT PROCESS. A  
9 HEALTH BENEFIT PAYER THAT CONDUCTS AN AUDIT OF A PHARMACY IN THIS  
10 STATE SHALL NOT INTERFERE WITH THE DELIVERY OF PHARMACY SERVICES TO  
11 A PATIENT.

12 (D) CONDUCT AN AUDIT THAT INVOLVES CLINICAL OR PROFESSIONAL  
13 JUDGMENT BY OR IN CONSULTATION WITH A PHARMACIST LICENSED IN THIS  
14 STATE.

15 (E) SUBJECT TO THE REQUIREMENTS OF THIS ARTICLE, FOR THE  
16 PURPOSE OF VALIDATING A PHARMACY RECORD WITH RESPECT TO ORDERS OR  
17 REFILLS, ALLOW THE USE OF HOSPITAL OR PHYSICIAN RECORDS THAT ARE  
18 WRITTEN OR THAT ARE TRANSMITTED OR STORED ELECTRONICALLY, INCLUDING  
19 FILE ANNOTATIONS, DOCUMENT IMAGES, AND OTHER SUPPORTING  
20 DOCUMENTATION THAT ARE DATE- AND TIME-STAMPED.

21 (F) BASE ANY FINDING OF AN OVERPAYMENT OR UNDERPAYMENT ON THE  
22 ACTUAL OVERPAYMENT OR UNDERPAYMENT OF CLAIMS.

23 (G) BASE ANY RECOUPMENT OR PAYMENT ADJUSTMENTS OF CLAIMS ON A  
24 CALCULATION THAT IS REASONABLE AND PROPORTIONAL IN RELATION TO THE  
25 TYPE OF ERROR DETECTED.

26 (H) IF THERE IS A FINDING OF AN UNDERPAYMENT, REIMBURSE THE  
27 PHARMACY AS SOON AS POSSIBLE AFTER DETECTION.

1 (I) CONDUCT ITS AUDIT OF EACH PHARMACY UNDER THE SAME SAMPLING  
2 STANDARDS, PARAMETERS, AND PROCEDURES AS OTHER SIMILARLY LICENSED  
3 PHARMACIES AUDITED BY THE HEALTH BENEFIT PAYER. THE HEALTH BENEFIT  
4 PAYER SHALL PROVIDE TO THE PHARMACY SAMPLES OF THE STANDARD  
5 PARAMETERS AND PROCEDURES FOR THE AUDIT BEING CONDUCTED.

6 (J) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION, AUDIT  
7 ONLY CLAIMS SUBMITTED OR ADJUDICATED WITHIN THE 2-YEAR PERIOD  
8 IMMEDIATELY PRECEDING THE INITIATION OF THE AUDIT UNLESS A LONGER  
9 PERIOD IS PERMITTED UNDER FEDERAL OR STATE LAW. THIS SUBDIVISION  
10 DOES NOT APPLY UNDER ANY OF THE FOLLOWING CIRCUMSTANCES:

11 (i) WHEN A HEALTH BENEFIT PAYER MUST RETURN TO A PHARMACY TO  
12 COMPLETE AN AUDIT ALREADY IN PROGRESS.

13 (ii) IF THERE IS A DOCUMENTED PATTERN OF PAYMENT ERROR  
14 SUSTAINED BY THAT PHARMACY THROUGHOUT THE AUDITED PERIOD.

15 (iii) IF THERE IS INAPPROPRIATE OR ILLEGAL ACTIVITY THAT THE  
16 HEALTH BENEFIT PAYER HAS BROUGHT TO THE ATTENTION OF THE PHARMACY  
17 OWNER OR CORPORATE HEADQUARTERS OF THE PHARMACY.

18 (K) NOT RECEIVE PAYMENT BASED ON RISK- OR INCENTIVE-BASED  
19 AUDITING.

20 (L) NOT INCLUDE THE DISPENSING FEE AMOUNT IN A FINDING OF AN  
21 OVERPAYMENT.

22 (2) UPON COMPLETION OF AN AUDIT OF A PHARMACY, THE HEALTH  
23 BENEFIT PAYER SHALL DO ALL OF THE FOLLOWING:

24 (A) DELIVER A PRELIMINARY WRITTEN AUDIT REPORT TO THE PHARMACY  
25 ON OR BEFORE THE EXPIRATION OF 120 DAYS AFTER THE COMPLETION OF THE  
26 AUDIT, WITH REASONABLE EXTENSIONS ALLOWED. THE PRELIMINARY WRITTEN  
27 AUDIT REPORT SHALL INCLUDE CONTACT INFORMATION FOR THE AUDITING

1 ENTITY AND A DESCRIPTION OF THE APPEAL PROCESS DEVELOPED UNDER  
2 SUBSECTION (3) .

3 (B) ALLOW THE PHARMACY NOT LESS THAN 60 DAYS FOLLOWING ITS  
4 RECEIPT OF THE PRELIMINARY REPORT UNDER SUBDIVISION (A) TO PRODUCE  
5 DOCUMENTATION TO ADDRESS ANY DISCREPANCY FOUND DURING THE AUDIT.

6 (C) IF AN APPEAL IS NOT FILED UNDER SUBSECTION (3) , DELIVER A  
7 FINAL WRITTEN AUDIT REPORT TO THE PHARMACY ON OR BEFORE THE  
8 EXPIRATION OF 6 MONTHS AFTER THE TIME PERIOD DESCRIBED IN  
9 SUBDIVISION (B) HAS ELAPSED. IF AN APPEAL IS FILED UNDER SUBSECTION  
10 (3) , DELIVER A FINAL WRITTEN AUDIT REPORT TO THE PHARMACY ON OR  
11 BEFORE THE EXPIRATION OF 6 MONTHS AFTER THE CONCLUSION OF THE  
12 APPEAL. THE FINAL WRITTEN AUDIT REPORT SHALL INCLUDE CONTACT  
13 INFORMATION FOR THE AUDITING ENTITY AND BE SIGNED BY AND INCLUDE  
14 THE SIGNATURE OF ANY PHARMACIST PARTICIPATING IN THE AUDIT.

15 (D) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION, ONLY  
16 RECOUP DISPUTED FUNDS OR OVERPAYMENTS OR RESTORE UNDERPAYMENTS  
17 AFTER THE FINAL WRITTEN AUDIT REPORT IS DELIVERED TO THE PHARMACY  
18 UNDER SUBDIVISION (C) . THE BENEFIT PAYER SHALL RESTORE  
19 UNDERPAYMENTS TO THE PHARMACY IN THE NEXT PAYMENT CYCLE. IF THE  
20 PRELIMINARY WRITTEN AUDIT REPORT UNDER SUBDIVISION (A) DISCLOSES A  
21 DISCREPANCY THAT EXCEEDS \$20,000.00 IN OVERPAYMENT, A HEALTH  
22 BENEFIT PAYER MAY WITHHOLD FUTURE PAYMENTS TO THE PHARMACY DURING  
23 THE PERIOD BEGINNING ON THE DATE THE PRELIMINARY AUDIT REPORT IS  
24 DELIVERED TO THE PHARMACY UNDER SUBDIVISION (A) THROUGH THE DATE  
25 THE AUDIT IS FINALIZED UNDER SUBDIVISION (C) .

26 (E) DISCLOSE TO THE SPONSOR OF THE HEALTH CARE PAYMENT OR  
27 BENEFITS PROGRAM ANY MONEY RECOUPED THROUGH THE AUDIT PROCESS.

1 (F) PROVIDE TO THE SPONSOR OF THE HEALTH CARE PAYMENT OR  
2 BENEFITS PROGRAM A COPY OF THE FINAL WRITTEN AUDIT REPORT DELIVERED  
3 TO THE PHARMACY UNDER SUBDIVISION (C).

4 (3) THE COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE  
5 REGULATION SHALL ESTABLISH AN APPEALS PROCESS FOR THE CONDUCT  
6 BEFORE A NEUTRAL PARTY OF AN APPEAL OF AN AUDIT REPORT PREPARED  
7 UNDER THIS SECTION. THE EVALUATION OF CLAIMS SUBMISSION AND PRODUCT  
8 SIZE DISPUTES IN AN APPEAL UNDER THIS SUBSECTION SHALL BE BASED  
9 UPON STANDARDS DEVELOPED BY THE NATIONAL COUNCIL FOR PRESCRIPTION  
10 DRUG PROGRAMS OR ANY OTHER RECOGNIZED NATIONAL INDUSTRY STANDARD  
11 APPROVED BY THE COMMISSIONER. IF, FOLLOWING AN APPEAL, THE APPEALED  
12 PORTION OF THE AUDIT REPORT IS UNSUBSTANTIATED, THE HEALTH BENEFIT  
13 PAYER SHALL DISMISS THE PORTION OF THE AUDIT REPORT IN QUESTION  
14 WITHOUT THE NECESSITY OF ANY FURTHER ACTION.

15 (4) THE HEALTH BENEFIT PAYER SHALL NOT CONDUCT AN  
16 EXTRAPOLATION AUDIT IN CALCULATING RECOUPMENTS, RESTORATION, OR  
17 PENALTIES FOR AN AUDIT UNDER THIS SECTION. FOR THE PURPOSES OF THIS  
18 SUBSECTION, AN EXTRAPOLATION AUDIT IS AN AUDIT OF A SAMPLE OF  
19 PRESCRIPTION DRUG BENEFIT CLAIMS SUBMITTED BY A PHARMACY TO THE  
20 HEALTH BENEFIT PAYER THAT IS THEN USED TO ESTIMATE AUDIT RESULTS  
21 FOR A LARGER BATCH OR GROUP OF CLAIMS NOT REVIEWED DURING THE  
22 AUDIT. A HEALTH BENEFIT PAYER SHALL BASE AUDIT CONCLUSIONS ON 1 OR  
23 MORE OF THE FOLLOWING STATISTICAL CONSIDERATIONS:

24 (A) THE AUDIT SAMPLE SHALL CONSIST OF RANDOMLY SELECTED  
25 PRESCRIPTIONS WITH DATES OF SERVICE INCLUDED WITHIN THE STATED  
26 AUDIT PERIOD.

27 (B) CLAIMS IN THE SAMPLE FOR WHICH A PHARMACY WAS UNDERPAID

1 SHALL BE CONSIDERED AS WELL AS ANY CLAIMS IN THE SAMPLE INVOLVING  
2 OVERPAYMENTS.

3 (C) THE SAMPLE SHALL NOT INCLUDE SOLELY HIGH-PRICED  
4 MEDICATIONS OR A PREPONDERANCE OF THE SAME DRUG ITEM.

5 (D) THE SAMPLE SIZE SHALL BE APPROPRIATE AND CONSISTENT WITH  
6 ESTABLISHED SCIENTIFIC PRINCIPLES ASSURING PROTECTION AGAINST  
7 SELECTION BIAS.

8 (E) THE STANDARD DEVIATION OR THE STANDARD ERROR EMPLOYED BY  
9 THE SPECIFIC AUDITING METHODOLOGY SHALL BE DEFINED AND CONSISTENT  
10 WITH COMMONLY ACCEPTED SCIENTIFIC PRINCIPLES.

11 (F) IF THERE IS AN IMPASSE OCCURRING OVER METHODOLOGY, SAMPLE  
12 SIZE, OR RANDOMNESS THAT ACCOMPANIES AN AUDIT CONCLUSION, THE  
13 DECISION OF THE OFFICE OF FINANCIAL AND INSURANCE REGULATION IN  
14 CONSULTATION WITH A QUALIFIED STATISTICIAN IS FINAL.

15 (5) ANY CLERICAL OR RECORD-KEEPING ERROR, INCLUDING A  
16 TYPOGRAPHICAL ERROR, A SCRIVENER'S ERROR, OR A COMPUTER ERROR,  
17 REGARDING A REQUIRED DOCUMENT OR RECORD THAT IS FOUND DURING AN  
18 AUDIT UNDER THIS SECTION DOES NOT, ON ITS FACE, CONSTITUTE FRAUD.  
19 AN ERROR DESCRIBED IN THIS SUBSECTION DOES NOT SUBJECT THE  
20 INDIVIDUAL INVOLVED TO CRIMINAL PENALTIES WITHOUT PROOF OF INTENT  
21 TO COMMIT FRAUD. AN ERROR DESCRIBED IN THIS SUBSECTION MAY BE  
22 SUBJECT TO RECOUPMENT.

23 (6) THE AUDIT CRITERIA SET FORTH IN THIS SECTION APPLY ONLY TO  
24 AUDITS OF CLAIMS FOR SERVICES PROVIDED AND CLAIMS SUBMITTED FOR  
25 PAYMENT AFTER OCTOBER 1, 2012.

26 (7) THIS SECTION DOES NOT APPLY TO ANY OF THE FOLLOWING:

27 (A) A HEALTH BENEFIT PAYER PHARMACY AUDIT OR INVESTIGATIVE

1 AUDIT CONDUCTED BY OR ON BEHALF OF A STATE AGENCY THAT INVOLVES  
2 FRAUD, WILLFUL MISREPRESENTATION, OR ABUSE, INCLUDING WITHOUT  
3 LIMITATION INVESTIGATIVE AUDITS OR ANY OTHER STATUTORY PROVISION  
4 THAT AUTHORIZES INVESTIGATION RELATING TO INSURANCE FRAUD.

5 (B) AN AUDIT BASED ON A CRIMINAL INVESTIGATION.

6 (8) THIS SECTION DOES NOT IMPAIR OR SUPERSEDE A PROVISION  
7 REGARDING HEALTH BENEFIT PAYER PHARMACY AUDITS IN THE INSURANCE  
8 CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302, OR THE  
9 NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL  
10 550.1101 TO 550.1704. IF ANY PROVISION OF THIS SECTION CONFLICTS  
11 WITH A PROVISION OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL  
12 500.100 TO 500.8302, OR THE NONPROFIT HEALTH CARE CORPORATION  
13 REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704, WITH REGARD TO  
14 HEALTH BENEFIT PAYER PHARMACY AUDITS, THE APPLICABLE PROVISION IN  
15 THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302,  
16 OR THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350,  
17 MCL 550.1101 TO 550.1704, CONTROLS.

18 (9) AS USED IN THIS SECTION:

19 (A) "CLAIM" MEANS ANY ATTEMPT TO CAUSE AN ENTITY TO MAKE A  
20 PAYMENT TO COVER A HEALTH CARE BENEFIT UNDER A HEALTH CARE PAYMENT  
21 OR BENEFITS PROGRAM.

22 (B) "HEALTH BENEFIT PAYER" MEANS A PUBLIC OR PRIVATE ENTITY  
23 THAT OFFERS, PROVIDES, ADMINISTERS, OR MANAGES A HEALTH CARE  
24 PAYMENT OR BENEFITS PROGRAM, INCLUDING, BUT NOT LIMITED TO, ALL OF  
25 THE FOLLOWING:

26 (i) A HEALTH INSURER OR ANY INSURANCE COMPANY AUTHORIZED TO  
27 PROVIDE HEALTH INSURANCE IN THIS STATE.

1 (ii) A NONPROFIT HEALTH CARE CORPORATION.

2 (iii) A HEALTH MAINTENANCE ORGANIZATION.

3 (iv) A PREFERRED PROVIDER ORGANIZATION.

4 (v) A NONPROFIT DENTAL CARE CORPORATION.

5 (vi) THE MEDICAL SERVICES ADMINISTRATION IN THE DEPARTMENT OF  
6 COMMUNITY HEALTH.

7 (vii) A PHARMACY BENEFIT MANAGER.

8 (viii) A LEGAL ENTITY THAT IS SELF-INSURED AND PROVIDING HEALTH  
9 CARE BENEFITS TO ITS EMPLOYEES.

10 (ix) A RESPONSIBLE PARTY.

11 (x) A PERSON ACTING FOR AN ENTITY DESCRIBED IN SUBPARAGRAPHS  
12 (i) TO (ix) IN A CONTRACTUAL RELATIONSHIP IN THE PERFORMANCE OF ANY  
13 ACTIVITY ON BEHALF OF THE ENTITY DESCRIBED IN SUBPARAGRAPHS (i) TO  
14 (viii) .

15 (C) "HEALTH CARE BENEFIT" MEANS THE RIGHT UNDER A HEALTH CARE  
16 PAYMENT OR BENEFITS PROGRAM TO HAVE A PAYMENT MADE BY A HEALTH  
17 BENEFIT PAYER FOR A SPECIFIED HEALTH CARE SERVICE.

18 (D) "HEALTH CARE PAYMENT OR BENEFITS PROGRAM " MEANS AN  
19 EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR  
20 CERTIFICATE, NONPROFIT HEALTH CARE CORPORATION CERTIFICATE, HEALTH  
21 MAINTENANCE ORGANIZATION CONTRACT, AND ANY OTHER PLAN OR PROGRAM OF  
22 HEALTH CARE BENEFITS THAT PROVIDES COVERAGE FOR OR ADMINISTERS  
23 COVERAGE FOR PRESCRIPTION DRUGS OR DEVICES.

24 (E) "PHARMACY BENEFIT MANAGER" MEANS A PERSON, BUSINESS, OR  
25 OTHER LEGAL ENTITY THAT ORCHESTRATES THE DEVELOPMENT OF THE  
26 PHARMACY NETWORK AND ADJUDICATES CLAIMS FOR A HEALTH BENEFIT PAYER.

27 (F) "RESPONSIBLE PARTY" MEANS AN ENTITY THAT IS RESPONSIBLE



- 1 FOR THE PAYMENT OF CLAIMS FOR HEALTH CARE BENEFITS UNDER A HEALTH
- 2 CARE PAYMENT OR BENEFITS PROGRAM.