SENATE BILL No. 42

January 16, 2013, Introduced by Senators CASWELL and JANSEN 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 17771.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 17771. (1) SUBJECT TO THIS SECTION, A HEALTH BENEFIT PAYER MAY CONDUCT AN AUDIT OF A PHARMACY IN THIS STATE. A HEALTH BENEFIT PAYER THAT CONDUCTS AN AUDIT OF A PHARMACY IN THIS STATE SHALL DO ALL OF THE FOLLOWING:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(*l*) NOT INCLUDE THE DISPENSING FEE AMOUNT IN A FINDING OF AN OVERPAYMENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) THE AUDIT CRITERIA SET FORTH IN THIS SECTION APPLY ONLY TO AUDITS OF CLAIMS FOR SERVICES PROVIDED AND CLAIMS SUBMITTED FOR PAYMENT AFTER OCTOBER 1, 2013.

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

(A) A HEALTH BENEFIT PAYER PHARMACY AUDIT OR INVESTIGATIVE

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

(B) AN AUDIT BASED ON A CRIMINAL INVESTIGATION.

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

(9) AS USED IN THIS SECTION:

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

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

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

(*ii*) A NONPROFIT HEALTH CARE CORPORATION.

(*iii*) A HEALTH MAINTENANCE ORGANIZATION.

(*iv*) A PREFERRED PROVIDER ORGANIZATION.

(*v*) A NONPROFIT DENTAL CARE CORPORATION.

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

(*vii*) A PHARMACY BENEFIT MANAGER.

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

(*ix*) A RESPONSIBLE PARTY.

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

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

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

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

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

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