HOUSE BILL No. 5475

September 25, 2009, Introduced by Reps. Simpson, Mayes, Cushingberry, Spade, Sheltrown, Geiss, Womack, Huckleberry and Slavens and referred to the Committee on Health Policy.

A bill to amend 1984 PA 323, entitled

"The health care false claim act,"

by amending section 2 (MCL 752.1002) and by adding section 8b.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2. As used in this act:

(a) "Claim" means any attempt to cause a health care corporation or health care insurer to make the payment of a health care benefit.

(b) "Deceptive" means making a claim to a health care corporation or health care insurer which contains a statement of fact or which fails to reveal a material fact, which statement or failure leads the health care corporation or health care insurer to believe the represented or suggested state of affair to be other

HOUSE BILL No. 5475

than it actually is.

(c) "False" means wholly or partially untrue or deceptive.

(d) "Health care benefit" means the right under a contract or a certificate or policy of insurance to have a payment made by a health care corporation or health care insurer for a specified health care service.

(e) "Health care corporation" means a nonprofit dental care corporation incorporated under ~~Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws~~ **1963 PA 125, MCL 550.351 TO 550.373**; a hospital service corporation, medical care corporation, or a consolidated hospital service corporation and medical care corporation incorporated or reincorporated under ~~Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, or incorporated or consolidated under Act No. 108 or 109 of the Public Acts of 1939~~ **THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704**; or a health maintenance organization licensed under ~~Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws~~ **CHAPTER 35 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3501 TO 500.3580**.

(f) "Health care insurer" means any insurance company authorized to provide health insurance in this state or any legal entity which is self-insured and providing health care benefits to its employees.

(g) "Health facility or agency" means a health facility or agency, as defined in section 20106 of the public health code, ~~Act~~

~~No. 368 of the Public Acts of 1978, being section 333.20106 of the Michigan Compiled Laws~~ **1978 PA 368, MCL 333.20106.**

(h) "Knowing" and "knowingly" means that a person is in possession of facts under which he or she is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the payment of a health care benefit. "Knowing" or "knowingly" does not include conduct which is an error or mistake unless the person's course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present.

(i) "Person" means an individual, corporation, partnership, association, or any other legal entity.

(J) "PHARMACY BENEFIT MANAGER" OR "PBM" MEANS A PERSON, BUSINESS, OR ENTITY THAT PERFORMS PHARMACY BENEFITS MANAGEMENT. PHARMACY BENEFIT MANAGER OR PBM INCLUDES A PERSON OR ENTITY ACTING FOR A PBM IN A CONTRACTUAL OR EMPLOYMENT RELATIONSHIP IN THE PERFORMANCE OF PHARMACY BENEFITS MANAGEMENT FOR A MANAGED CARE COMPANY, MEDICAL SERVICE ORGANIZATION, INSURANCE COMPANY, THIRD-PARTY PAYOR, OR A HEALTH PROGRAM ADMINISTERED BY A STATE DEPARTMENT AND INCLUDES ANY PERSON, CORPORATION, BUSINESS, COMPANY, ASSOCIATION, UNION, HEALTH CARE GROUP, NETWORK, COLLECTIVE BARGAINING GROUP, OR ANY OTHER ENTITY THAT PROVIDES PRESCRIPTION DRUGS OR MEDICAL SUPPLIES, OR BOTH.

(K) "PHARMACY BENEFITS MANAGEMENT" MEANS THE ADMINISTRATIVE PROCEDURES INVOLVED IN THE DELIVERY OF THE PRESCRIPTION DRUG BENEFIT, INCLUDING, BUT NOT LIMITED TO, CONSTRUCTION AND MANAGEMENT OF FORMULARIES, NEGOTIATION WITH AND MANAGEMENT OF PROVIDER

NETWORKS, DETERMINATION OF CONSUMER COST-SHARING REQUIREMENTS, COMMUNICATION OF BENEFIT STATUS TO CONSUMERS, CLAIMS PROCESSING, AND NEGOTIATED REBATES AND DISCOUNTS.

SEC. 8B. (1) THE PBM OR ENTITY CONDUCTING AN AUDIT SHALL FOLLOW THESE PROCEDURES:

(A) THE PHARMACY CONTRACT MUST IDENTIFY AND DESCRIBE IN DETAIL THE AUDIT PROCEDURES.

(B) THE PBM OR ENTITY CONDUCTING THE AUDIT SHALL PROVIDE THE PHARMACY WITH WRITTEN NOTICE AT LEAST 2 WEEKS BEFORE CONDUCTING THE INITIAL ON-SITE OR OFF-SITE AUDIT FOR EACH AUDIT CYCLE.

(C) THE PBM OR ENTITY CONDUCTING THE ON-SITE AUDIT SHALL NOT INTERFERE WITH THE DELIVERY OF PHARMACIST SERVICES TO A PATIENT AND SHALL UTILIZE EVERY EFFORT TO MINIMIZE INCONVENIENCE AND DISRUPTION TO PHARMACY OPERATIONS DURING THE AUDIT PROCESS. AN ENTITY SHALL NOT CONDUCT AN ON-SITE AUDIT AT A PARTICULAR PHARMACY MORE THAN 1 TIME ANNUALLY. THIS SUBDIVISION DOES NOT APPLY WHEN AN ENTITY MUST RETURN TO A PHARMACY TO COMPLETE AN AUDIT ALREADY IN PROGRESS, THERE IS A DOCUMENTED PATTERN OF PAYMENT ERROR SUSTAINED BY THAT SPECIFIC PHARMACY THROUGHOUT THE AUDITED PERIOD, OR THERE IS INAPPROPRIATE OR ILLEGAL ACTIVITY THAT THE ENTITY HAS BROUGHT TO THE ATTENTION OF THE PHARMACY OWNER OR CORPORATE HEADQUARTERS OF THE PHARMACY.

(D) ANY AUDIT THAT INVOLVES CLINICAL OR PROFESSIONAL JUDGMENT MUST BE CONDUCTED BY OR IN CONSULTATION WITH A PHARMACIST LICENSED IN THIS STATE.

(E) ANY CLERICAL OR RECORD-KEEPING ERROR, SUCH AS A TYPOGRAPHICAL ERROR, SCRIVENER'S ERROR, OR COMPUTER ERROR,

REGARDING A REQUIRED DOCUMENT OR RECORD SHALL NOT ON ITS FACE CONSTITUTE FRAUD, BUT MAY BE SUBJECT TO RECOUPMENT. A CLAIM UNDER THIS SUBDIVISION IS NOT SUBJECT TO CRIMINAL PENALTIES WITHOUT PROOF OF INTENT TO COMMIT FRAUD.

(F) A PHARMACY MAY USE ELECTRONIC RECORDS, INCLUDING ELECTRONIC BENEFICIARY SIGNATURE LOGS, ELECTRONIC TRACKING OF PRESCRIPTIONS, ELECTRONIC PRESCRIBER PRESCRIPTION TRANSMISSIONS AND IMAGERY OF HARD COPY PRESCRIPTIONS, AND ANY OTHER REASONABLY CLEAR AND ACCURATE ELECTRONIC DOCUMENTATION, AND THESE RECORDS ARE ACCEPTABLE FOR AUDITING UNDER THE SAME TERMS AND CONDITIONS AND FOR THE SAME PURPOSES AS THEIR PAPER ANALOGS. IF PAPER LOGS ARE USED, AUDITORS MUST LOOK AT LEAST 14 DAYS PAST THE DISPENSE DATE TO CHECK FOR PATIENT PICKUP. POINT OF SALE ELECTRONIC REGISTER DATA SHALL QUALIFY AS PROOF OF DELIVERY TO THE PATIENT.

(G) A FINDING OF AN OVERPAYMENT OR UNDERPAYMENT MUST BE BASED ON THE ACTUAL OVERPAYMENT OR UNDERPAYMENT AND MAY NOT BE A PROJECTION BASED ON THE NUMBER OF PATIENTS SERVED HAVING A SIMILAR DIAGNOSIS OR ON THE NUMBER OF SIMILAR ORDERS OR REFILLS FOR SIMILAR DRUGS. RECOUPMENT OF CLAIMS MUST BE BASED ON THE ACTUAL OVERPAYMENT OR UNDERPAYMENT UNLESS THE PHARMACY AGREES OTHERWISE AS PART OF A SETTLEMENT.

(H) RECOUPMENT OR PAYMENT ADJUSTMENTS OF CLAIMS MUST BE BASED ON THE ACTUAL OVERPAYMENT OR UNDERPAYMENT UNLESS THE PHARMACY AGREES TO A PROJECTION AS PART OF A SETTLEMENT.

(I) A FINDING OF AN UNDERPAYMENT SHALL BE REIMBURSED WITH INTEREST FOR THE TIME PERIOD BETWEEN DETECTION AND PAYMENT.

(J) EACH PHARMACY SHALL BE AUDITED UNDER THE SAME SAMPLING

STANDARDS, PARAMETERS, AND PROCEDURES AS OTHER SIMILARLY LICENSED PHARMACIES AUDITED BY THE PBM OR ENTITY CONDUCTING THE AUDIT. THE PHARMACY SHALL BE PROVIDED SAMPLES OF THE STANDARD PARAMETERS AND PROCEDURES FOR THE AUDITS BEING CONDUCTED.

(K) THE PERIOD COVERED BY AN AUDIT MAY NOT EXCEED 1 YEAR FROM THE DATE THE CLAIM WAS SUBMITTED TO OR ADJUDICATED BY A MANAGED CARE COMPANY, MEDICAL SERVICE ORGANIZATION, INSURANCE COMPANY, THIRD-PARTY PAYOR, OR HEALTH PROGRAM ADMINISTERED BY A STATE DEPARTMENT.

(*l*) AN ON-SITE AUDIT MAY NOT BE INITIATED OR SCHEDULED DURING THE FIRST 7 CALENDAR DAYS OF ANY MONTH DUE TO THE HIGH VOLUME OF PRESCRIPTIONS FILLED IN THE PHARMACY DURING THAT TIME UNLESS OTHERWISE CONSENTED TO BY THE PHARMACIST. THE PBM IS RESPONSIBLE FOR CONFIRMING RECEIPT OF THE AUDIT NOTICE BY THE PHARMACY. THE PHARMACY RESERVES THE RIGHT TO REFUSE TO COMPLY WITH ANY AUDIT FOR WHICH THE PBM DID NOT CONFIRM, AND THE PBM IS PROHIBITED FROM TAKING ANY ADVERSE ACTION AGAINST THE PHARMACY DUE TO THE REFUSAL BY THE PHARMACY UNDER THIS SUBDIVISION.

(M) THE PBM OR ENTITY CONDUCTING AN AUDIT MAY NOT RECEIVE PAYMENT BASED ON A PERCENTAGE OF THE AMOUNT RECOVERED. THE PBM OR ENTITY CONDUCTING THE AUDIT SHALL DISCLOSE TO THE PLAN SPONSOR ANY MONEY RECOUPED IN THE AUDIT.

(N) IF THE DISCREPANCY EXCEEDS $25,000.00 IN OVERPAYMENT, FUTURE PAYMENTS TO THE PHARMACY MAY BE WITHHELD AFTER FINALIZATION OF THE AUDIT.

(O) UNDERPAYMENTS SHALL BE RESTORED IN THE NEXT PAYMENT CYCLE UPON COMPLETION OF THE AUDIT.

(P) A FINDING OF AN OVERPAYMENT SHALL NOT INCLUDE THE DISPENSING FEE AMOUNT.

(2) THE PBM OR ENTITY CONDUCTING THE AUDIT MUST PROVIDE THE PHARMACY WITH A WRITTEN REPORT OF THE AUDIT AND COMPLY WITH ALL OF THE FOLLOWING REQUIREMENTS:

(A) THE PRELIMINARY AUDIT REPORT MUST BE DELIVERED TO THE PHARMACY NOT MORE THAN 90 DAYS AFTER CONCLUSION OF THE AUDIT.

(B) THE PHARMACY SHALL BE ALLOWED NOT LESS THAN 60 DAYS FOLLOWING RECEIPT OF THE PRELIMINARY AUDIT REPORT IN WHICH TO PRODUCE DOCUMENTATION TO ADDRESS ANY DISCREPANCY FOUND DURING THE AUDIT.

(C) A FINAL AUDIT REPORT SHALL BE DELIVERED TO THE PHARMACY NOT MORE THAN 120 DAYS AFTER RECEIPT OF THE PRELIMINARY AUDIT REPORT OR FINAL APPEAL WITH THE OFFICE OF FINANCIAL AND INSURANCE REGULATION.

(D) THE AUDIT REPORT MUST BE SIGNED AND INCLUDE THE SIGNATURE OF ANY PHARMACIST PARTICIPATING IN THE AUDIT.

(E) ANY RECOUPMENTS OF DISPUTED FUNDS AND RESTORATION OF OVERPAYMENT SHALL ONLY OCCUR AFTER FINAL INTERNAL DISPOSITION OF THE AUDIT, INCLUDING THE APPEALS PROCESS AS SET FORTH IN SUBSECTION (3).

(F) INTEREST SHALL NOT ACCRUE DURING THE AUDIT PERIOD.

(G) EACH PBM OR ENTITY CONDUCTING AN AUDIT SHALL PROVIDE A COPY OF THE FINAL AUDIT REPORT, AFTER COMPLETION OF ANY REVIEW PROCESS, TO THE PLAN SPONSOR.

(3) THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS OR ANY OTHER RECOGNIZED NATIONAL INDUSTRY STANDARD SHALL BE USED TO

EVALUATE CLAIMS SUBMISSION AND PRODUCT SIZE DISPUTES. AN APPEALS PROCESS WILL BE CONDUCTED BY THE OFFICE OF FINANCIAL AND INSURANCE REGULATION BEFORE A NEUTRAL PARTY. IF, FOLLOWING THE APPEAL, THE PBM OR ENTITY CONDUCTING AN AUDIT FINDS THAT AN UNFAVORABLE AUDIT REPORT OR ANY PORTION OF THAT REPORT IS UNSUBSTANTIATED, THE PBM OR ENTITY CONDUCTING THE AUDIT SHALL DISMISS THE AUDIT REPORT OR PORTION IN QUESTION WITHOUT THE NECESSITY OF ANY FURTHER ACTION.

(4) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, THE PBM OR ENTITY CONDUCTING THE AUDIT SHALL NOT USE THE ACCOUNTING PRACTICE OF EXTRAPOLATION IN CALCULATING RECOUPMENTS, RESTORATION, OR PENALTIES FOR AUDITS. AN EXTRAPOLATION AUDIT MEANS AN AUDIT OF A SAMPLE OF PRESCRIPTION DRUG BENEFIT CLAIMS SUBMITTED BY A PHARMACY TO THE PBM OR ENTITY CONDUCTING THE AUDIT THAT IS THEN USED TO ESTIMATE AUDIT RESULTS FOR A LARGER BATCH OR GROUP OF CLAIMS NOT REVIEWED BY THE AUDITOR. AUDIT CONCLUSIONS SHALL BE BASED ON SEVERAL 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. THE PBM SHALL REIMBURSE THE PHARMACY FOR ALL TIME AND EXPENSES INCURRED IN PROVIDING DOCUMENTS FOR THE AUDIT.

(B) CLAIMS IN THE SAMPLE, FOR WHICH A PHARMACY WAS UNDERPAID, ARE CONSIDERED AS WELL AS ANY CLAIMS IN THE SAMPLE INVOLVING OVERPAYMENTS.

(C) THE AUDIT SAMPLE SHALL REFLECT THE COMPOSITION OF THE PHARMACY'S CLAIMS, INCLUDING, BUT NOT LIMITED TO, A RANDOM SAMPLE THAT INCLUDES THE SAME RATIO OF BRAND NAME TO GENERIC PRESCRIPTIONS OR PROPORTION OF COMPOUNDING, SPECIALTY, HIGH-COST MEDICATIONS, OR

OTHER UNIQUE CHARACTERISTICS OF THE PROFILE OF PRESCRIPTIONS DISPENSED.

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

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

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

(G) IN THE EVENT OF 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 WILL BE FINAL.

(5) THE AUDIT CRITERIA SET FORTH IN THIS SECTION APPLIES ONLY TO AUDITS OF CLAIMS FOR SERVICES PROVIDED AND CLAIMS SUBMITTED FOR PAYMENT AFTER JANUARY 1, 2010. THIS SECTION DOES NOT APPLY TO ANY 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.