SENATE BILL No. 1000

June 12, 2014, Introduced by Senators SCHUITMAKER and CASWELL and referred to the Committee on Insurance.

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 INCLUDING THE APPEALS PROCESS DESCRIBED IN SUBDIVISION (M). 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

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BEFORE INITIATING AND SCHEDULING THE INITIAL ON-SITE AUDIT FOR EACH AUDIT CYCLE. A HEALTH BENEFIT PAYER SHALL NOT INITIATE OR SCHEDULE AN ON-SITE AUDIT DURING THE FIRST 6 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.

(E) SUBJECT TO THE REQUIREMENTS OF THIS ARTICLE, FOR THE PURPOSE OF VALIDATING A PHARMACY RECORD WITH RESPECT TO ORDERS, REFILLS, OR CHANGES IN PRESCRIPTIONS, ALLOW THE USE OF EITHER OF THE FOLLOWING:

(*i*) 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.

(*ii*) A PRESCRIPTION THAT COMPLIES WITH BOARD REQUIREMENTS AND STATE AND FEDERAL LAW.

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

(G) SUBJECT TO SUBSECTION (4), 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 THAT THE HEALTH BENEFIT PAYER USES WHEN AUDITING OTHER SIMILARLY LICENSED PHARMACIES. THE HEALTH BENEFIT PAYER SHALL PROVIDE TO THE PHARMACY SAMPLES OF THE STANDARDS, PARAMETERS, AND PROCEDURES FOR THE AUDIT BEING CONDUCTED.

(J) 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.

(K) NOT RECEIVE PAYMENT BASED ON A PERCENTAGE OF THE AMOUNT RECOVERED.

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

(M) ESTABLISH A WRITTEN APPEALS PROCESS THAT INCLUDES A PROCESS TO APPEAL PRELIMINARY AUDIT REPORTS AND FINAL AUDIT REPORTS PREPARED UNDER THIS SECTION. IF EITHER PARTY IS NOT SATISFIED WITH THE RESULTS OF THE APPEAL, THAT PARTY MAY SEEK MEDIATION.

(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 60 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 ESTABLISHED UNDER SUBSECTION (1)(M).

(B) ALLOW THE PHARMACY AT LEAST 30 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, DELIVER A FINAL WRITTEN AUDIT REPORT TO THE PHARMACY WITHIN 90 DAYS AFTER THE TIME DESCRIBED IN SUBDIVISION (B) HAS ELAPSED. IF AN APPEAL IS FILED, DELIVER A FINAL WRITTEN AUDIT REPORT TO THE PHARMACY WITHIN 90 DAYS AFTER THE CONCLUSION OF THE APPEAL.

(D) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, ONLY RECOUP DISPUTED FUNDS OR OVERPAYMENTS OR RESTORE UNDERPAYMENTS AFTER THE FINAL WRITTEN AUDIT REPORT IS DELIVERED TO THE PHARMACY UNDER SUBDIVISION (C).

(E) UPON REQUEST, 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) A 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.

(4) 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. TO THE EXTENT THAT AN AUDIT RESULTS IN THE IDENTIFICATION OF A CLERICAL OR RECORD-KEEPING ERROR, INCLUDING A TYPOGRAPHICAL ERROR, A SCRIVENER'S ERROR, OR A COMPUTER ERROR, IN A REQUIRED DOCUMENT OR RECORD, THE PHARMACY MUST NOT BE SUBJECT TO RECOUPMENT OF FUNDS BY THE HEALTH BENEFIT PAYER UNLESS THE HEALTH BENEFIT PAYER CAN PROVIDE PROOF OF INTENT TO COMMIT FRAUD OR THE ERROR RESULTS IN ACTUAL FINANCIAL HARM TO THE HEALTH BENEFIT PAYER OR A COVERED INDIVIDUAL UNDER A HEALTH CARE PAYMENT OR BENEFITS PROGRAM.

(5) 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, BUT NOT LIMITED TO, INVESTIGATIVE AUDITS OR AUDITS CONDUCTED UNDER ANY OTHER STATUTORY PROVISION THAT AUTHORIZES INVESTIGATION RELATING TO INSURANCE FRAUD.

(B) AN AUDIT BASED ON A CRIMINAL INVESTIGATION.

(6) 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. 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, WITH REGARD TO HEALTH BENEFIT PAYER PHARMACY AUDITS, THE PROVISION IN THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302,

CONTROLS.

(7) 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 (*ix*).

(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, 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 THAT TERM AS DEFINED IN SECTION 2 OF THE THIRD PARTY ADMINISTRATOR ACT, 1984 PA 218, MCL 550.902.

(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.