HB3285

LRB10009755SMS19924b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB3285

by Rep. Robert Rita

SYNOPSIS AS INTRODUCED:

215 ILCS 5/512-11 new
215 ILCS 5/512-12 new
215 ILCS 5/512-13 new

Amends the Illinois Insurance Code. Provides that all entities providing prescription drug coverage shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a pharmacy for less than a 30-day supply if the prescriber or pharmacist indicates the fill or refill could be in the best interest of the patient or is for the purpose of synchronizing the patient's chronic medications. Provides that no entity providing prescription drug coverage shall deny coverage for the dispensing of any drug prescribed for the treatment of a chronic illness that is made in accordance with a plan among the insured, the prescriber, and a pharmacist to synchronize the refilling of multiple prescriptions for the insured. Provides that no entity providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees determined by calculation of the days' supply of medication dispensed. Provides that dispensing fees shall be determined exclusively on the total number of prescriptions dispensed. Establishes criteria for an entity conducting audits (either on-site or remotely) of pharmacy records. Provides that the Department of Insurance and Director of Insurance shall have the authority to enforce the provisions of the Act and impose financial penalties. Effective January 1, 2018.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by adding Sections 512-11, 512-12, and 512-13 as follows:

(215 ILCS 5/512-11 new)

Sec. 512-11. Medication synchronization. All entities providing prescription drug coverage shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a pharmacy for less than a 30-day supply if the prescriber or pharmacist indicates the fill or refill could be in the best interest of the patient or is for the purpose of synchronizing the patient's chronic medications.

No entity providing prescription drug coverage shall deny coverage for the dispensing of any drug prescribed for the treatment of a chronic illness that is made in accordance with a plan among the insured, the prescriber, and a pharmacist to synchronize the refilling of multiple prescriptions for the insured.

No entity providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees determined by calculation of the days' supply of medication dispensed. Dispensing fees shall be determined exclusively on

the total number of prescriptions dispensed.

The provisions of this Section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified-disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, or short-term major medical policy of 6 months or less in duration or any other supplemental policy.

(215 ILCS 5/512-12 new)

Sec. 512-12. Audit of pharmacy records.

(a) Notwithstanding any other law, when an entity is conducting a retrospective audit of the records of a pharmacy for its reimbursements claims (on-site or remotely) or performs concurrent daily reviews, the auditing entity must comply with the following:

(1) The entity conducting the initial on-site audit shall give the pharmacy and the pharmacy's corporate office written notice at least 30 days before conducting the initial on-site audit for each audit cycle and shall disclose the specific prescriptions to be included in the audit.

(2) Unless otherwise consented to by the pharmacy, an audit shall not be initiated or scheduled during the first 7 calendar days of any month or the day before or after a federal or State holiday due to the high volume of

prescriptions filled during that time.

(3) When an entity is conducting an on-site audit, it 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. The on-site audit shall not exceed 4 hours in duration and shall review no more than 100 unique prescription numbers during an initial audit.

(4) No entity shall conduct an on-site audit at a particular pharmacy more than one time annually. However, this paragraph (4) shall not apply when an entity must return to a pharmacy to complete an audit already in progress.

(5) The period covered by an audit shall not exceed 2 years from the date the initial prescription claim was submitted to or adjudicated by an entity.

(6) Each pharmacy shall be audited under the same auditing standards and parameters used for conducting audits of other contracted network pharmacies under each pharmacy network contract that a pharmacy benefits manager or health plan utilizes in this State. Any documentation and records required by an auditor during an audit shall be of the same type as the documentation and records required for other contracted network pharmacies under each pharmacy provider network contract that a pharmacy

benefits manager or health plan utilizes in this State.

(7) Any audit that involves clinical or professional judgment shall be conducted by or in consultation with a pharmacist licensed under the Pharmacy Practice Act.

(8) Each audit shall be conducted by a field agent who possesses the requisite expertise in pharmacy practice in this State.

(9) Any unintentional clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not necessarily constitute fraud. These claims may be subject to recoupment, but shall not subject a pharmacy to criminal penalties without proof of intent to commit fraud. In the case of errors which have no financial harm to the patient or plan, the entity must not assess any chargebacks.

(10) All audits shall be conducted in accordance with generally accepted accounting principles, standards, and procedures; and auditing principles, standards, and procedures; and using standards and parameters established by rule that are identical for all audits conducted.

(11) An entity conducting daily concurrent reviews, either directly or on behalf of a pharmacy benefits manager, must complete the concurrent reviews and allow final processing for final claim adjudication within 3 business days or 5 calendar days, whichever is sooner,

after the initial adjudication effort for the claim.

(12) Prescriptions are considered valid prescriptions if they are compliant with the Pharmacy Practice Act and Illinois Controlled Substances Act and have been positively adjudicated upon claim submission by the entity. Plan restrictions should be addressed during the claims adjudication process either through the rejection of the claim or a rejection of the claim with direction to obtain a prior authorization and may not be the basis for a retrospective recoupment of a paid claim.

(13) 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.

(14) With the exception of overpayments, if a pharmacy benefits manager approves a claim through adjudication, the pharmacy benefits manager may not retroactively deny or modify reimbursement based on information accompanying the original claim or information available to the pharmacy benefits manager at the time of adjudication, unless the claim was fraudulent, the pharmacy or pharmacist had been reimbursed for the claim previously, or the services reimbursed were not rendered by the pharmacy or pharmacist.

(15) A pharmacy benefits manager may not require more information to be written on a prescription than is

required by State or federal law. Nor may a pharmacy benefits manager require more stringent records to validate a prescription order than is required by State or federal law.

(16) Electronic records, including electronic beneficiary signature logs, electronic tracking of prescriptions, electronic prescriber prescription transmissions and imagery of hard copy prescriptions, electronically scanned store, patient records maintained at or accessible to the offices of an audited pharmacy's central operations, and any other reasonably clear and accurate electronic documentation shall be 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.

(17) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend drug or other controlled substance.

(18) Validation of appropriate day's supply and drug dosing must be based on manufacturer guidelines and

definitions or, in the case of topical products or titrated products, the professional judgment of the pharmacist based upon communication with the patient or prescriber.

(19) A pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless an alternate price is published in the provider contract and signed by both parties.

(20) A pharmacy benefits manager may not require a pharmacy to agree to recoupments deducted against future remittances and shall invoice the pharmacy for payment if the pharmacy elects. Recoupment may be deducted against future remittances without mutual consent when the pharmacy is considered delinquent in payment of the invoice per the contractual arrangement.

(21) Interest shall not accrue during the audit period.

(22) Notwithstanding any other provision in this subsection (a), the entity conducting the audit shall be prohibited from using the accounting practice of extrapolation in calculating recoupments or penalties for audits. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not on 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.

(23) A finding of an overpayment shall not include the dispensing fee amount.

(24) The preliminary audit report shall be delivered by the entity to the pharmacy and pharmacy corporate office within 30 days, with reasonable extensions allowed, after conclusion of the audit and shall contain individual claim level information for any discrepancy found and total dollar amount of claims subject to recovery, organized by plan sponsor, identified by organization name, for which each claim is associated.

(25) A pharmacy shall be allowed at least 30 days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit or to file an appeal.

(26) A final audit report containing claim level information for any discrepancy found and total dollar amount of claims subject to recovery shall be delivered to the pharmacy and pharmacy corporate office within 45 days after the audited pharmacy's receipt of the preliminary audit report if the audited pharmacy does not file an appeal or offers no documentation to address a discrepancy found during an audit, or within 60 days after the auditing entity receives the audited pharmacy's appeal or documentation to address a discrepancy. The final audit results shall be reflected in the remittance advice at the claim level.

(27) The entity shall establish an appeals process that meets the following requirements:

(A) 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.

(B) Each entity conducting an audit shall establish a written appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(C) If, following the appeal, the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or said portion without the necessity of any further action.

(28) A pharmacy benefits manager may not recover payment of claims from the pharmacy which is identified through the audit process to be the responsibility of another payer. The pharmacy benefits manager must reconcile directly with the other payer for any moneys owed without requiring the pharmacy to reverse and rebill the original claim in the retail setting.

(29) Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor and to the contracted network pharmacy within 3 business days after its completion by the entity.

(30) The full amount of any recoupment on an audit

shall be refunded to the plan sponsor. Written documentation of the refund with the refund date and plan sponsor's name and address shall be provided to the contracted network pharmacy subjected to the audit recoupment.

(31) Neither the agency conducting the audit nor its agents shall receive payment based on a percentage of the amount recovered. This Section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(A) the plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and

(B) a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

(32) The entity conducting the audit shall not base compensation of any employees of the entity involved with the audit process on a percentage of the amount recovered or audit findings.

(b) Except as otherwise provided in subsection (a), all recoupments from final audits of pharmacies are to be considered property of the plan sponsor. The entity shall be

required to refund recoupments to each plan sponsor associated with the audited claims.

(c) Recoupments of any disputed funds shall occur after final internal disposition of the audit, including the appeals process as set forth in subsection (d).

(d) Notwithstanding any other law, each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal a preliminary audit report to the entity.

(e) This Section does not apply to any audit, review, or investigation that involves allegations of fraud, willful misrepresentation, or abuse.

(215 ILCS 5/512-13 new)

Sec. 512-13. Enforcement.

(a) Enforcement of this Article shall be the responsibility of the Department and the Director.

(b) The Director shall have the authority to adopt any rules necessary for the implementation and administration of this Article.

(c) The Director shall take action or impose penalties to bring non-complying entities into full compliance with this Article. Any violation of this Article may subject a non-complying entity to financial penalties not less than $1,000 per violation.

Section 99. Effective date. This Act takes effect January 1, 2018.