MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representative Yancey To: Insurance

HOUSE BILL NO. 1299

1 AN ACT TO REQUIRE PHARMACY BENEFIT MANAGERS TO MAKE AVAILABLE
2 TO THE PUBLIC UPON REQUEST, AND WITHOUT REDACTION, CONTRACTS
3 RELATING TO PHARMACY BENEFIT MANAGEMENT SERVICES BETWEEN A
4 PHARMACY BENEFIT MANAGER AND ANY ENTITY; TO BRING FORWARD SECTIONS
5 73-21-153, 73-21-155, 73-21-156, 73-21-157, 73-21-159, 73-21-161
6 AND 73-21-163, MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE
7 PHARMACY BENEFIT PROMPT PAY ACT, FOR PURPOSES OF POSSIBLE
8 AMENDMENT; TO BRING FORWARD SECTIONS 73-21-177, 73-21-179,
9 73-21-181, 73-21-183, 73-21-185, 73-21-187, 73-21-189 AND
10 73-21-191, MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE PHARMACY
11 AUDIT INTEGRITY ACT, FOR PURPOSES OF POSSIBLE AMENDMENT; AND FOR
12 RELATED PURPOSES.

13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

14 **SECTION 1.** Notwithstanding any law to the contrary, a
15 pharmacy benefit manager shall make available to the public upon
16 request, and without redaction, contracts relating to pharmacy
17 benefit management services between a pharmacy benefit manager and
18 any entity, at the beginning of the term of the contract, and upon
19 renewal of the contract.

20 **SECTION 2.** Section 73-21-153, Mississippi Code of 1972, is
21 brought forward as follows:

22 73-21-153. For purposes of Sections 73-21-151 through
23 73-21-163, the following words and phrases shall have the meanings
24 ascribed herein unless the context clearly indicates otherwise:
25 (a) "Board" means the State Board of Pharmacy.
26 (b) "Commissioner" means the Mississippi Commissioner
27 of Insurance.
28 (c) "Day" means a calendar day, unless otherwise
29 defined or limited.
30 (d) "Electronic claim" means the transmission of data
31 for purposes of payment of covered prescription drugs, other
32 products and supplies, and pharmacist services in an electronic
33 data format specified by a pharmacy benefit manager and approved
34 by the department.
35 (e) "Electronic adjudication" means the process of
36 electronically receiving, reviewing and accepting or rejecting an
37 electronic claim.
38 (f) "Enrollee" means an individual who has been
39 enrolled in a pharmacy benefit management plan.
40 (g) "Health insurance plan" means benefits consisting
41 of prescription drugs, other products and supplies, and pharmacist
42 services provided directly, through insurance or reimbursement, or
43 otherwise and including items and services paid for as
44 prescription drugs, other products and supplies, and pharmacist
45 services under any hospital or medical service policy or
46 certificate, hospital or medical service plan contract, preferred

47 provider organization agreement, or health maintenance
48 organization contract offered by a health insurance issuer.
49 (h) "Pharmacy benefit manager" shall have the same
50 definition as provided in Section 73-21-179. However, through
51 June 30, 2014, the term "pharmacy benefit manager" shall not
52 include an insurance company that provides an integrated health
53 benefit plan and that does not separately contract for pharmacy
54 benefit management services. From and after July 1, 2014, the
55 term "pharmacy benefit manager" shall not include an insurance
56 company unless the insurance company is providing services as a
57 pharmacy benefit manager as defined in Section 73-21-179, in which
58 case the insurance company shall be subject to Sections 73-21-151
59 through 73-21-159 only for those pharmacy benefit manager
60 services. In addition, the term "pharmacy benefit manager" shall
61 not include the pharmacy benefit manager of the Mississippi State
62 and School Employees Health Insurance Plan or the Mississippi
63 Division of Medicaid or its contractors when performing pharmacy
64 benefit manager services for the Division of Medicaid.
65 (i) "Pharmacy benefit manager affiliate" means a
66 pharmacy or pharmacist that directly or indirectly, through one or
67 more intermediaries, owns or controls, is owned or controlled by,
68 or is under common ownership or control with a pharmacy benefit
69 manager.
70 (j) "Pharmacy benefit management plan" shall have the
71 same definition as provided in Section 73-21-179.

72 (k) "Pharmacist," "pharmacist services" and "pharmacy"
73 or "pharmacies" shall have the same definitions as provided in
74 Section 73-21-73.
75 (l) "Uniform claim form" means a form prescribed by
76 rule by the State Board of Pharmacy; however, for purposes of
77 Sections 73-21-151 through 73-21-159, the board shall adopt the
78 same definition or rule where the State Department of Insurance
79 has adopted a rule covering the same type of claim. The board may
80 modify the terminology of the rule and form when necessary to
81 comply with the provisions of Sections 73-21-151 through
82 73-21-159.
83 (m) "Plan sponsors" means the employers, insurance
84 companies, unions and health maintenance organizations that
85 contract with a pharmacy benefit manager for delivery of
86 prescription services.
87 **SECTION 3.** Section 73-21-155, Mississippi Code of 1972, is
88 brought forward as follows:
89 73-21-155. (1) Reimbursement under a contract to a
90 pharmacist or pharmacy for prescription drugs and other products
91 and supplies that is calculated according to a formula that uses
92 Medi-Span, Gold Standard or a nationally recognized reference that
93 has been approved by the board in the pricing calculation shall
94 use the most current reference price or amount in the actual or
95 constructive possession of the pharmacy benefit manager, its
96 agent, or any other party responsible for reimbursement for

97 prescription drugs and other products and supplies on the date of
98 electronic adjudication or on the date of service shown on the
99 nonelectronic claim.
100 (2) Pharmacy benefit managers, their agents and other
101 parties responsible for reimbursement for prescription drugs and
102 other products and supplies shall be required to update the
103 nationally recognized reference prices or amounts used for
104 calculation of reimbursement for prescription drugs and other
105 products and supplies no less than every three (3) business days.
106 (3) (a) All benefits payable under a pharmacy benefit
107 management plan shall be paid within seven (7) days after receipt
108 of due written proof of a clean claim where claims are submitted
109 electronically, and shall be paid within thirty-five (35) days
110 after receipt of due written proof of a clean claim where claims
111 are submitted in paper format. Benefits due under the plan and
112 claims are overdue if not paid within seven (7) days or
113 thirty-five (35) days, whichever is applicable, after the pharmacy
114 benefit manager receives a clean claim containing necessary
115 information essential for the pharmacy benefit manager to
116 administer preexisting condition, coordination of benefits and
117 subrogation provisions under the plan sponsor's health insurance
118 plan. A "clean claim" means a claim received by any pharmacy
119 benefit manager for adjudication and which requires no further
120 information, adjustment or alteration by the pharmacist or
121 pharmacies or the insured in order to be processed and paid by the

122 pharmacy benefit manager. A claim is clean if it has no defect or
123 impropriety, including any lack of substantiating documentation,
124 or particular circumstance requiring special treatment that
125 prevents timely payment from being made on the claim under this
126 subsection. A clean claim includes resubmitted claims with
127 previously identified deficiencies corrected.

128 (b) A clean claim does not include any of the
129 following:

130 (i) A duplicate claim, which means an original
131 claim and its duplicate when the duplicate is filed within thirty
132 (30) days of the original claim;

133 (ii) Claims which are submitted fraudulently or
134 that are based upon material misrepresentations;

135 (iii) Claims that require information essential
136 for the pharmacy benefit manager to administer preexisting
137 condition, coordination of benefits or subrogation provisions
138 under the plan sponsor's health insurance plan; or

139 (iv) Claims submitted by a pharmacist or pharmacy
140 more than thirty (30) days after the date of service; if the
141 pharmacist or pharmacy does not submit the claim on behalf of the
142 insured, then a claim is not clean when submitted more than thirty
143 (30) days after the date of billing by the pharmacist or pharmacy
144 to the insured.

145 (c) Not later than seven (7) days after the date the
146 pharmacy benefit manager actually receives an electronic claim,

147 the pharmacy benefit manager shall pay the appropriate benefit in
148 full, or any portion of the claim that is clean, and notify the
149 pharmacist or pharmacy (where the claim is owed to the pharmacist
150 or pharmacy) of the reasons why the claim or portion thereof is
151 not clean and will not be paid and what substantiating
152 documentation and information is required to adjudicate the claim
153 as clean. Not later than thirty-five (35) days after the date the
154 pharmacy benefit manager actually receives a paper claim, the
155 pharmacy benefit manager shall pay the appropriate benefit in
156 full, or any portion of the claim that is clean, and notify the
157 pharmacist or pharmacy (where the claim is owed to the pharmacist
158 or pharmacy) of the reasons why the claim or portion thereof is
159 not clean and will not be paid and what substantiating
160 documentation and information is required to adjudicate the claim
161 as clean. Any claim or portion thereof resubmitted with the
162 supporting documentation and information requested by the pharmacy
163 benefit manager shall be paid within twenty (20) days after
164 receipt.
165 (4) If the board finds that any pharmacy benefit manager,
166 agent or other party responsible for reimbursement for
167 prescription drugs and other products and supplies has not paid
168 ninety-five percent (95%) of clean claims as defined in subsection
169 (3) of this section received from all pharmacies in a calendar
170 quarter, he shall be subject to administrative penalty of not more

171 than Twenty-five Thousand Dollars ($25,000.00) to be assessed by
172 the State Board of Pharmacy.

173 (a) Examinations to determine compliance with this
174 subsection may be conducted by the board. The board may contract
175 with qualified impartial outside sources to assist in examinations
176 to determine compliance. The expenses of any such examinations
177 shall be paid by the pharmacy benefit manager examined.

178 (b) Nothing in the provisions of this section shall
179 require a pharmacy benefit manager to pay claims that are not
180 covered under the terms of a contract or policy of accident and
181 sickness insurance or prepaid coverage.

182 (c) If the claim is not denied for valid and proper
183 reasons by the end of the applicable time period prescribed in
184 this provision, the pharmacy benefit manager must pay the pharmacy
185 (where the claim is owed to the pharmacy) or the patient (where
186 the claim is owed to a patient) interest on accrued benefits at
187 the rate of one and one-half percent (1-1/2%) per month accruing
188 from the day after payment was due on the amount of the benefits
189 that remain unpaid until the claim is finally settled or
190 adjudicated. Whenever interest due pursuant to this provision is
191 less than One Dollar ($1.00), such amount shall be credited to the
192 account of the person or entity to whom such amount is owed.

193 (d) Any pharmacy benefit manager and a pharmacy may
194 enter into an express written agreement containing timely claim
195 payment provisions which differ from, but are at least as

196 stringent as, the provisions set forth under subsection (3) of
197 this section, and in such case, the provisions of the written
198 agreement shall govern the timely payment of claims by the
199 pharmacy benefit manager to the pharmacy. If the express written
200 agreement is silent as to any interest penalty where claims are
201 not paid in accordance with the agreement, the interest penalty
202 provision of subsection (4)(c) of this section shall apply.
203 (e) The State Board of Pharmacy may adopt rules and
204 regulations necessary to ensure compliance with this subsection.
205 (5) (a) For purposes of this subsection (5), "network
206 pharmacy" means a licensed pharmacy in this state that has a
207 contract with a pharmacy benefit manager to provide covered drugs
208 at a negotiated reimbursement rate. A network pharmacy or
209 pharmacist may decline to provide a brand name drug, multisource
210 generic drug, or service, if the network pharmacy or pharmacist is
211 paid less than that network pharmacy's acquisition cost for the
212 product. If the network pharmacy or pharmacist declines to
213 provide such drug or service, the pharmacy or pharmacist shall
214 provide the customer with adequate information as to where the
215 prescription for the drug or service may be filled.
216 (b) The State Board of Pharmacy shall adopt rules and
217 regulations necessary to implement and ensure compliance with this
218 subsection, including, but not limited to, rules and regulations
219 that address access to pharmacy services in rural or underserved
220 areas in cases where a network pharmacy or pharmacist declines to

221 provide a drug or service under paragraph (a) of this subsection.
222 The board shall promulgate the rules and regulations required by
223 this paragraph (b) not later than October 1, 2016.
224 (6) A pharmacy benefit manager shall not directly or
225 indirectly retroactively deny or reduce a claim or aggregate of
226 claims after the claim or aggregate of claims has been
227 adjudicated.
228 **SECTION 4.** Section 73-21-156, Mississippi Code of 1972, is
229 brought forward as follows:
230 73-21-156. (1) As used in this section, the following terms
231 shall be defined as provided in this subsection:
232 (a) "Maximum allowable cost list" means a listing of
233 drugs or other methodology used by a pharmacy benefit manager,
234 directly or indirectly, setting the maximum allowable payment to a
235 pharmacy or pharmacist for a generic drug, brand-name drug,
236 biologic product or other prescription drug. The term "maximum
237 allowable cost list" includes without limitation:
238 (i) Average acquisition cost, including national
239 average drug acquisition cost;
240 (ii) Average manufacturer price;
241 (iii) Average wholesale price;
242 (iv) Brand effective rate or generic effective
243 rate;
244 (v) Discount indexing;
245 (vi) Federal upper limits;

246 (vii) Wholesale acquisition cost; and

247 (viii) Any other term that a pharmacy benefit
248 manager or a health care insurer may use to establish
249 reimbursement rates to a pharmacist or pharmacy for pharmacist
250 services.

251 (b) "Pharmacy acquisition cost" means the amount that a
252 pharmaceutical wholesaler charges for a pharmaceutical product as
253 listed on the pharmacy's billing invoice.

254 (2) Before a pharmacy benefit manager places or continues a
255 particular drug on a maximum allowable cost list, the drug:

256 (a) If the drug is a generic equivalent drug product as
257 defined in 73-21-73, shall be listed as therapeutically equivalent
258 and pharmaceutically equivalent "A" or "B" rated in the United
259 States Food and Drug Administration's most recent version of the
260 "Orange Book" or "Green Book" or have an NR or NA rating by
261 Medi-Span, Gold Standard, or a similar rating by a nationally
262 recognized reference approved by the board;

263 (b) Shall be available for purchase by each pharmacy in
264 the state from national or regional wholesalers operating in
265 Mississippi; and

266 (c) Shall not be obsolete.

267 (3) A pharmacy benefit manager shall:

268 (a) Provide access to its maximum allowable cost list
269 to each pharmacy subject to the maximum allowable cost list;

270 (b) Update its maximum allowable cost list on a timely
271 basis, but in no event longer than three (3) calendar days; and
272 (c) Provide a process for each pharmacy subject to the
273 maximum allowable cost list to receive prompt notification of an
274 update to the maximum allowable cost list.
275 (4) A pharmacy benefit manager shall:
276 (a) Provide a reasonable administrative appeal
277 procedure to allow pharmacies to challenge a maximum allowable
278 cost list and reimbursements made under a maximum allowable cost
279 list for a specific drug or drugs as:
280 (i) Not meeting the requirements of this section;
281 or
282 (ii) Being below the pharmacy acquisition cost.
283 (b) The reasonable administrative appeal procedure
284 shall include the following:
285 (i) A dedicated telephone number, email address
286 and website for the purpose of submitting administrative appeals;
287 (ii) The ability to submit an administrative
288 appeal directly to the pharmacy benefit manager regarding the
289 pharmacy benefit management plan or through a pharmacy service
290 administrative organization; and
291 (iii) A period of less than thirty (30) business
292 days to file an administrative appeal.

293 (c) The pharmacy benefit manager shall respond to the
294 challenge under paragraph (a) of this subsection (4) within thirty
295 (30) business days after receipt of the challenge.
296 (d) If a challenge is made under paragraph (a) of this
297 subsection (4), the pharmacy benefit manager shall within thirty
298 (30) business days after receipt of the challenge either:
299 (i) If the appeal is upheld:
300 1. Make the change in the maximum allowable
301 cost list payment to at least the pharmacy acquisition cost;
302 2. Permit the challenging pharmacy or
303 pharmacist to reverse and rebill the claim in question;
304 3. Provide the National Drug Code that the
305 increase or change is based on to the pharmacy or pharmacist; and
306 4. Make the change under item 1 of this
307 subparagraph (i) effective for each similarly situated pharmacy as
308 defined by the payor subject to the maximum allowable cost list;
309 or
310 (ii) If the appeal is denied, provide the
311 challenging pharmacy or pharmacist the National Drug Code and the
312 name of the national or regional pharmaceutical wholesalers
313 operating in Mississippi that have the drug currently in stock at
314 a price below the maximum allowable cost as listed on the maximum
315 allowable cost list; or
316 (iii) If the National Drug Code provided by the
317 pharmacy benefit manager is not available below the pharmacy

318 acquisition cost from the pharmaceutical wholesaler from whom the
319 pharmacy or pharmacist purchases the majority of prescription
320 drugs for resale, then the pharmacy benefit manager shall adjust
321 the maximum allowable cost as listed on the maximum allowable cost
322 list above the challenging pharmacy's pharmacy acquisition cost
323 and permit the pharmacy to reverse and rebill each claim affected
324 by the inability to procure the drug at a cost that is equal to or
325 less than the previously challenged maximum allowable cost.
326 (5) (a) A pharmacy benefit manager shall not reimburse a
327 pharmacy or pharmacist in the state an amount less than the amount
328 that the pharmacy benefit manager reimburses a pharmacy benefit
329 manager affiliate for providing the same pharmacist services.
330 (b) The amount shall be calculated on a per unit basis
331 based on the same brand and generic product identifier or brand
332 and generic code number.
333 **SECTION 5.** Section 73-21-157, Mississippi Code of 1972, is
334 brought forward as follows:
335 73-21-157. (1) Before beginning to do business as a
336 pharmacy benefit manager, a pharmacy benefit manager shall obtain
337 a license to do business from the board. To obtain a license, the
338 applicant shall submit an application to the board on a form to be
339 prescribed by the board.
340 (2) Each pharmacy benefit manager providing pharmacy
341 management benefit plans in this state shall file a statement with
342 the board annually by March 1 or within sixty (60) days of the end

343 of its fiscal year if not a calendar year. The statement shall be
344 verified by at least two (2) principal officers and shall cover
345 the preceding calendar year or the immediately preceding fiscal
346 year of the pharmacy benefit manager.

347 (3) The statement shall be on forms prescribed by the board
348 and shall include:

349 (a) A financial statement of the organization,
350 including its balance sheet and income statement for the preceding
351 year; and

352 (b) Any other information relating to the operations of
353 the pharmacy benefit manager required by the board under this
354 section.

355 (4) (a) Any information required to be submitted to the
356 board pursuant to licensure application that is considered
357 proprietary by a pharmacy benefit manager shall be marked as
358 confidential when submitted to the board. All such information
359 shall not be subject to the provisions of the federal Freedom of
360 Information Act or the Mississippi Public Records Act and shall
361 not be released by the board unless subject to an order from a
362 court of competent jurisdiction. The board shall destroy or
363 delete or cause to be destroyed or deleted all such information
364 thirty (30) days after the board determines that the information
365 is no longer necessary or useful.

366 (b) Any person who knowingly releases, causes to be
367 released or assists in the release of any such information shall

368 be subject to a monetary penalty imposed by the board in an amount
369 not exceeding Fifty Thousand Dollars ($50,000.00) per violation.
370 When the board is considering the imposition of any penalty under
371 this paragraph (b), it shall follow the same policies and
372 procedures provided for the imposition of other sanctions in the
373 Pharmacy Practice Act. Any penalty collected under this paragraph
374 (b) shall be deposited into the special fund of the board and used
375 to support the operations of the board relating to the regulation
376 of pharmacy benefit managers.

377 (c) All employees of the board who have access to the
378 information described in paragraph (a) of this subsection shall be
379 fingerprinted, and the board shall submit a set of fingerprints
380 for each employee to the Department of Public Safety for the
381 purpose of conducting a criminal history records check. If no
382 disqualifying record is identified at the state level, the
383 Department of Public Safety shall forward the fingerprints to the
384 Federal Bureau of Investigation for a national criminal history
385 records check.

386 (5) If the pharmacy benefit manager is audited annually by
387 an independent certified public accountant, a copy of the
388 certified audit report shall be filed annually with the board by
389 June 30 or within thirty (30) days of the report being final.

390 (6) The board may extend the time prescribed for any
391 pharmacy benefit manager for filing annual statements or other
392 reports or exhibits of any kind for good cause shown. However,

393 the board shall not extend the time for filing annual statements
394 beyond sixty (60) days after the time prescribed by subsection (1)
395 of this section. The board may waive the requirements for filing
396 financial information for the pharmacy benefit manager if an
397 affiliate of the pharmacy benefit manager is already required to
398 file such information under current law with the Commissioner of
399 Insurance and allow the pharmacy benefit manager to file a copy of
400 documents containing such information with the board in lieu of
401 the statement required by this section.

402 (7) The expense of administering this section shall be
403 assessed annually by the board against all pharmacy benefit
404 managers operating in this state.

405 (8) A pharmacy benefit manager or third-party payor may not
406 require pharmacy accreditation standards or recertification
407 requirements inconsistent with, more stringent than, or in
408 addition to federal and state requirements for licensure as a
409 pharmacy in this state.

410 **SECTION 6.** Section 73-21-159, Mississippi Code of 1972, is
411 brought forward as follows:

412 73-21-159. (1) In lieu of or in addition to making its own
413 financial examination of a pharmacy benefit manager, the board may
414 accept the report of a financial examination of other persons
415 responsible for the pharmacy benefit manager under the laws of
416 another state certified by the applicable official of such other
417 state.

418 (2) The board shall coordinate financial examinations of a
419 pharmacy benefit manager that provides pharmacy management benefit
420 plans in this state to ensure an appropriate level of regulatory
421 oversight and to avoid any undue duplication of effort or
422 regulation. The pharmacy benefit manager being examined shall pay
423 the cost of the examination. The cost of the examination shall be
424 deposited in a special fund that shall provide all expenses for
425 the licensing, supervision and examination of all pharmacy benefit
426 managers subject to regulation under Sections 73-21-71 through
427 73-21-129 and Sections 73-21-151 through 73-21-163.
428 (3) The board may provide a copy of the financial
429 examination to the person or entity who provides or operates the
430 health insurance plan or to a pharmacist or pharmacy.
431 (4) The board is authorized to hire independent financial
432 consultants to conduct financial examinations of a pharmacy
433 benefit manager and to expend funds collected under this section
434 to pay the costs of such examinations.
435 **SECTION 7.** Section 73-21-161, Mississippi Code of 1972, is
436 brought forward as follows:
437 73-21-161. (1) As used in this section, the term "referral"
438 means:
439 (a) Ordering of a patient to a pharmacy by a pharmacy
440 benefit manager affiliate either orally or in writing, including
441 online messaging;

442 (b) Offering or implementing plan designs that require
443 patients to use affiliated pharmacies; or
444 (c) Patient or prospective patient specific
445 advertising, marketing, or promotion of a pharmacy by an
446 affiliate.
447 The term "referral" does not include a pharmacy's inclusion
448 by a pharmacy benefit manager affiliate in communications to
449 patients, including patient and prospective patient specific
450 communications, regarding network pharmacies and prices, provided
451 that the affiliate includes information regarding eligible
452 nonaffiliate pharmacies in those communications and the
453 information provided is accurate.
454 (2) A pharmacy, pharmacy benefit manager, or pharmacy
455 benefit manager affiliate licensed or operating in Mississippi
456 shall be prohibited from:
457 (a) Making referrals;
458 (b) Transferring or sharing records relative to
459 prescription information containing patient identifiable and
460 prescriber identifiable data to or from a pharmacy benefit manager
461 affiliate for any commercial purpose; however, nothing in this
462 section shall be construed to prohibit the exchange of
463 prescription information between a pharmacy and its affiliate for
464 the limited purposes of pharmacy reimbursement; formulary
465 compliance; pharmacy care; public health activities otherwise

466 authorized by law; or utilization review by a health care
467 provider; or
468 (c) Presenting a claim for payment to any individual,
469 third-party payor, affiliate, or other entity for a service
470 furnished pursuant to a referral from an affiliate.
471 (3) This section shall not be construed to prohibit a
472 pharmacy from entering into an agreement with a pharmacy benefit
473 manager affiliate to provide pharmacy care to patients, provided
474 that the pharmacy does not receive referrals in violation of
475 subsection (2) of this section and the pharmacy provides the
476 disclosures required in subsection (1) of this section.
477 (4) If a pharmacy licensed or holding a nonresident pharmacy
478 permit in this state has an affiliate, it shall annually file with
479 the board a disclosure statement identifying all such affiliates.
480 (5) In addition to any other remedy provided by law, a
481 violation of this section by a pharmacy shall be grounds for
482 disciplinary action by the board under its authority granted in
483 this chapter.
484 (6) A pharmacist who fills a prescription that violates
485 subsection (2) of this section shall not be liable under this
486 section.
487 **SECTION 8.** Section 73-21-163, Mississippi Code of 1972, is
488 brought forward as follows:
489 73-21-163. Whenever the board has reason to believe that a
490 pharmacy benefit manager or pharmacy benefit manager affiliate is

491 using, has used, or is about to use any method, act or practice
492 prohibited in Sections 73-21-151 through 73-21-163 and that
493 proceedings would be in the public interest, it may bring an
494 action in the name of the board against the pharmacy benefit
495 manager or pharmacy benefit manager affiliate to restrain by
496 temporary or permanent injunction the use of such method, act or
497 practice. The action shall be brought in the Chancery Court of
498 the First Judicial District of Hinds County, Mississippi. The
499 court is authorized to issue temporary or permanent injunctions to
500 restrain and prevent violations of Sections 73-21-151 through
501 73-21-163 and such injunctions shall be issued without bond.
502 (2) The board may impose a monetary penalty on a pharmacy
503 benefit manager or a pharmacy benefit manager affiliate for
504 noncompliance with the provisions of the Sections 73-21-151
505 through 73-21-163, in amounts of not less than One Thousand
506 Dollars ($1,000.00) per violation and not more than Twenty-five
507 Thousand Dollars ($25,000.00) per violation. Each day a violation
508 continues for the same brand or generic product identifier or
509 brand or generic code number is a separate violation. The board
510 shall prepare a record entered upon its minutes that states the
511 basic facts upon which the monetary penalty was imposed. Any
512 penalty collected under this subsection (2) shall be deposited
513 into the special fund of the board.
514 (3) The board may assess a monetary penalty for those
515 reasonable costs that are expended by the board in the

516 investigation and conduct of a proceeding if the board imposes a
517 monetary penalty under subsection (2) of this section. A monetary
518 penalty assessed and levied under this section shall be paid to
519 the board by the licensee, registrant or permit holder upon the
520 expiration of the period allowed for appeal of those penalties
521 under Section 73-21-101, or may be paid sooner if the licensee,
522 registrant or permit holder elects. Any penalty collected by the
523 board under this subsection (3) shall be deposited into the
524 special fund of the board.
525 (4) When payment of a monetary penalty assessed and levied
526 by the board against a licensee, registrant or permit holder in
527 accordance with this section is not paid by the licensee,
528 registrant or permit holder when due under this section, the board
529 shall have the power to institute and maintain proceedings in its
530 name for enforcement of payment in the chancery court of the
531 county and judicial district of residence of the licensee,
532 registrant or permit holder, or if the licensee, registrant or
533 permit holder is a nonresident of the State of Mississippi, in the
534 Chancery Court of the First Judicial District of Hinds County,
535 Mississippi. When those proceedings are instituted, the board
536 shall certify the record of its proceedings, together with all
537 documents and evidence, to the chancery court and the matter shall
538 be heard in due course by the court, which shall review the record
539 and make its determination thereon in accordance with the

540 provisions of Section 73-21-101. The hearing on the matter may,
541 in the discretion of the chancellor, be tried in vacation.
542 (5) The board shall develop and implement a uniform penalty
543 policy that sets the minimum and maximum penalty for any given
544 violation of Sections 73-21-151 through 73-21-163. The board
545 shall adhere to its uniform penalty policy except in those cases
546 where the board specifically finds, by majority vote, that a
547 penalty in excess of, or less than, the uniform penalty is
548 appropriate. That vote shall be reflected in the minutes of the
549 board and shall not be imposed unless it appears as having been
550 adopted by the board.
551 **SECTION 9.** Section 73-21-177, Mississippi Code of 1972, is
552 brought forward as follows:
553 73-21-177. The purpose of Sections 73-21-175 through
554 73-21-189 is to establish minimum and uniform standards and
555 criteria for the audit of pharmacy records by or on behalf of
556 certain entities.
557 **SECTION 10.** Section 73-21-179, Mississippi Code of 1972, is
558 brought forward as follows:
559 73-21-179. For purposes of Sections 73-21-175 through
560 73-21-189:
561 (a) "Entity" means a pharmacy benefit manager, a
562 managed care company, a health plan sponsor, an insurance company,
563 a third-party payor, or any company, group or agent that
564 represents or is engaged by those entities.

565 (b) "Health insurance plan" means benefits consisting
566 of prescription drugs, other products and supplies, and pharmacist
567 services provided directly, through insurance or reimbursement, or
568 otherwise and including items and services paid for as
569 prescription drugs, other products and supplies, and pharmacist
570 services under any hospital or medical service policy or
571 certificate, hospital or medical service plan contract, preferred
572 provider organization agreement, or health maintenance
573 organization contract offered by a health insurance
574 issuer.
575 (c) "Individual prescription" means the original
576 prescription for a drug signed by the prescriber, and excludes
577 refills referenced on the prescription.
578 (d) "Pharmacy benefit manager" means a business that
579 administers the prescription drug/device portion of pharmacy
580 benefit management plans or health insurance plans on behalf of
581 plan sponsors, insurance companies, unions and health maintenance
582 organizations. Pharmacy benefit managers may also provide some,
583 all, but may not be limited to, the following services either
584 directly or through outsourcing or contracts with other entities:
585 (i) Adjudicate drug claims or any portion of the
586 transaction.
587 (ii) Contract with retail and mail pharmacy
588 networks.
589 (iii) Establish payment levels for pharmacies.

590 (iv) Develop formulary or drug list of covered
591 therapies.
592 (v) Provide benefit design consultation.
593 (vi) Manage cost and utilization trends.
594 (vii) Contract for manufacturer rebates.
595 (viii) Provide fee-based clinical services to
596 improve member care.
597 (ix) Third-party administration.
598 (e) "Pharmacy benefit management plan" means an
599 arrangement for the delivery of pharmacist's services in which a
600 pharmacy benefit manager undertakes to administer the payment or
601 reimbursement of any of the costs of pharmacist's services for an
602 enrollee on a prepaid or insured basis that (i) contains one or
603 more incentive arrangements intended to influence the cost or
604 level of pharmacist's services between the plan sponsor and one or
605 more pharmacies with respect to the delivery of pharmacist's
606 services; and (ii) requires or creates benefit payment
607 differential incentives for enrollees to use under contract with
608 the pharmacy benefit manager.
609 (f) "Pharmacist," "pharmacist services" and "pharmacy"
610 or "pharmacies" shall have the same definitions as provided in
611 Section 73-21-73.
612 **SECTION 11.** Section 73-21-181, Mississippi Code of 1972, is
613 brought forward as follows:

614 73-21-181. Sections 73-21-175 through 73-21-189 shall apply
615 to any audit of the records of a pharmacy conducted by a managed
616 care company, nonprofit hospital or medical service organization,
617 insurance company, third-party payor, pharmacy benefit manager, a
618 health program administered by a department of the state or any
619 entity that represents those companies, groups, or department.

620 **SECTION 12.** Section 73-21-183, Mississippi Code of 1972, is
621 brought forward as follows:

622 73-21-183. (1) The entity conducting an audit shall follow
623 these procedures:

624 (a) The pharmacy contract must identify and describe in
625 detail the audit procedures;

626 (b) The entity conducting the on-site audit must give
627 the pharmacy written notice at least two (2) weeks before
628 conducting the initial on-site audit for each audit cycle, and the
629 pharmacy shall have at least fourteen (14) days to respond to any
630 desk audit requirements;

631 (c) The entity conducting the on-site or desk audit
632 shall not interfere with the delivery of pharmacist services to a
633 patient and shall utilize every effort to minimize inconvenience
634 and disruption to pharmacy operations during the audit process;

635 (d) Any audit that involves clinical or professional
636 judgment must be conducted by or in consultation with a
637 pharmacist;

638 (e) Any clerical or record-keeping error, such as a
639 typographical error, scrivener's error, or computer error,
640 regarding a required document or record shall not constitute
641 fraud; however, those claims may be subject to recoupment. No
642 such claim shall be subject to criminal penalties without proof of
643 intent to commit fraud;
644 (f) A pharmacy may use the records of a hospital,
645 physician, or other authorized practitioner of the healing arts
646 for drugs or medicinal supplies written or transmitted by any
647 means of communication for purposes of validating the pharmacy
648 record with respect to orders or refills of a legend or narcotic
649 drug;
650 (g) A finding of an overpayment or an underpayment may
651 be a projection based on the number of patients served having a
652 similar diagnosis or on the number of similar orders or refills
653 for similar drugs, except that recoupment shall be based on the
654 actual overpayment or underpayment;
655 (h) A finding of an overpayment shall not include the
656 dispensing fee amount unless a prescription was not dispensed;
657 (i) Each pharmacy shall be audited under the same
658 standards and parameters as other similarly situated pharmacies
659 audited by the entity;
660 (j) The period covered by an audit may not exceed two
661 (2) years from the date the claim was submitted to or adjudicated
662 by a managed care company, nonprofit hospital or medical service

663 organization, insurance company, third-party payor, pharmacy
664 benefit manager, a health program administered by a department of
665 the state or any entity that represents those companies, groups,
666 or department;
667 (k) An audit may not be initiated or scheduled during
668 the first five (5) calendar days of any month due to the high
669 volume of prescriptions filled in the pharmacy during that time
670 unless otherwise consented to by the pharmacy;
671 (l) Any prescription that complies with state law and
672 rule requirements may be used to validate claims in connection
673 with prescriptions, refills or changes in prescriptions;
674 (m) An exit interview that provides a pharmacy with an
675 opportunity to respond to questions and comment on and clarify
676 findings must be conducted at the end of an audit. The time of
677 the interview must be agreed to by the pharmacy;
678 (n) Unless superseded by state or federal law, auditors
679 shall only have access to previous audit reports on a particular
680 pharmacy conducted by the auditing entity for the same pharmacy
681 benefits manager, health plan or insurer. An auditing vendor
682 contracting with multiple pharmacy benefits managers or health
683 insurance plans shall not use audit reports or other information
684 gained from an audit on a particular pharmacy to conduct another
685 audit for a different pharmacy benefits manager or health
686 insurance plan;

687 (o) The parameters of an audit must comply with
688 consumer-oriented parameters based on manufacturer listings or
689 recommendations for the following:
690 (i) The day supply for eyedrops must be calculated
691 so that the consumer pays only one (1) thirty-day copayment if the
692 bottle of eyedrops is intended by the manufacturer to be a
693 thirty-day supply;
694 (ii) The day supply for insulin must be calculated
695 so that the highest dose prescribed is used to determine the day
696 supply and consumer copayment;
697 (iii) The day supply for a topical product must be
698 determined by the judgment of the pharmacist based upon the
699 treated area;
700 (p) (i) Where an audit is for a specifically
701 identified problem that has been disclosed to the pharmacy, the
702 audit shall be limited to claims that are identified by
703 prescription number;
704 (ii) For an audit other than described in
705 subparagraph (i) of this paragraph (p), an audit shall be limited
706 to one hundred (100) individual prescriptions that have been
707 randomly selected;
708 (iii) If an audit reveals the necessity for a
709 review of additional claims, the audit shall be conducted on site;

710 (iv) Except for audits initiated under paragraph
711 (i) of this subsection, an entity shall not initiate an audit of a
712 pharmacy more than one (1) time in any quarter;

713 (r) A recoupment shall not be based on:

714 (i) Documentation requirements in addition to or
715 exceeding requirements for creating or maintaining documentation
716 prescribed by the State Board of Pharmacy; or

717 (ii) A requirement that a pharmacy or pharmacist
718 perform a professional duty in addition to or exceeding
719 professional duties prescribed by the State Board of Pharmacy;

720 (s) Except for Medicare claims, approval of drug,
721 prescriber or patient eligibility upon adjudication of a claim
722 shall not be reversed unless the pharmacy or pharmacist obtained
723 the adjudication by fraud or misrepresentation of claim elements;
724 and

725 (t) A commission or other payment to an agent or
726 employee of the entity conducting the audit is not based, directly
727 or indirectly, on amounts recouped.

728 (2) The entity must provide the pharmacy with a written
729 report of the audit and comply with the following requirements:

730 (a) The preliminary audit report must be delivered to
731 the pharmacy within one hundred twenty (120) days after conclusion
732 of the audit, with a reasonable extension to be granted upon
733 request;

734 (b) A pharmacy shall be allowed at least thirty (30)
735 days following receipt of the preliminary audit report in which to
736 produce documentation to address any discrepancy found during the
737 audit, with a reasonable extension to be granted upon request;
738 (c) A final audit report shall be delivered to the
739 pharmacy within one hundred eighty (180) days after receipt of the
740 preliminary audit report or final appeal, as provided for in
741 Section 73-21-185, whichever is later;
742 (d) The audit report must be signed by the auditor;
743 (e) Recoupments of any disputed funds, or repayment of
744 funds to the entity by the pharmacy if permitted pursuant to
745 contractual agreement, shall occur after final internal
746 disposition of the audit, including the appeals process as set
747 forth in Section 73-21-185. If the identified discrepancy for an
748 individual audit exceeds Twenty-five Thousand Dollars
749 ($25,000.00), future payments in excess of that amount to the
750 pharmacy may be withheld pending finalization of the audit;
751 (f) Interest shall not accrue during the audit period;
752 and
753 (g) Each entity conducting an audit shall provide a
754 copy of the final audit report, after completion of any review
755 process, to the plan sponsor.
756 **SECTION 13.** Section 73-21-185, Mississippi Code of 1972, is
757 brought forward as follows:

758 73-21-185. (1) Each entity conducting an audit shall
759 establish a written appeals process under which a pharmacy may
760 appeal an unfavorable preliminary audit report to the entity.
761 (2) If, following the appeal, the entity finds that an
762 unfavorable audit report or any portion thereof is
763 unsubstantiated, the entity shall dismiss the audit report or that
764 portion without the necessity of any further action.
765 (3) If, following the appeal, any of the issues raised in
766 the appeal are not resolved to the satisfaction of either party,
767 that party may ask for mediation of those unresolved issues. A
768 certified mediator shall be chosen by agreement of the parties
769 from the Court Annexed Mediators List maintained by the
770 Mississippi Supreme Court.
771 **SECTION 14.** Section 73-21-187, Mississippi Code of 1972, is
772 brought forward as follows:
773 73-21-187. Notwithstanding any other provision in Sections
774 73-21-175 through 73-21-189, the entity conducting the audit shall
775 not use the accounting practice of extrapolation in calculating
776 recoupments or penalties for audits. An extrapolation audit means
777 an audit of a sample of prescription drug benefit claims submitted
778 by a pharmacy to the entity conducting the audit that is then used
779 to estimate audit results for a larger batch or group of claims
780 not reviewed by the auditor.
781 **SECTION 15.** Section 73-21-189, Mississippi Code of 1972, is
782 brought forward as follows:

783 73-21-189. Sections 73-21-175 through 73-21-189 do not apply
784 to any audit, review or investigation that involves alleged fraud,
785 willful misrepresentation or abuse.

786 **SECTION 16.** Section 73-21-191, Mississippi Code of 1972, is
787 brought forward as follows:

788 73-21-191. (1) The State Board of Pharmacy may impose a
789 monetary penalty on pharmacy benefit managers for noncompliance
790 with the provisions of the Pharmacy Audit Integrity Act, Sections
791 73-21-175 through 73-21-189, in amounts of not less than One
792 Thousand Dollars ($1,000.00) per violation and not more than
793 Twenty-five Thousand Dollars ($25,000.00) per violation. The
794 board shall prepare a record entered upon its minutes which states
795 the basic facts upon which the monetary penalty was imposed. Any
796 penalty collected under this subsection (1) shall be deposited
797 into the special fund of the board.

798 (2) The board may assess a monetary penalty for those
799 reasonable costs that are expended by the board in the
800 investigation and conduct of a proceeding if the board imposes a
801 monetary penalty under subsection (1) of this section. A monetary
802 penalty assessed and levied under this section shall be paid to
803 the board by the licensee, registrant or permit holder upon the
804 expiration of the period allowed for appeal of those penalties
805 under Section 73-21-101, or may be paid sooner if the licensee,
806 registrant or permit holder elects. Money collected by the board

807 under this subsection (2) shall be deposited to the credit of the
808 special fund of the board.
809 (3) When payment of a monetary penalty assessed and levied
810 by the board against a licensee, registrant or permit holder in
811 accordance with this section is not paid by the licensee,
812 registrant or permit holder when due under this section, the board
813 shall have the power to institute and maintain proceedings in its
814 name for enforcement of payment in the chancery court of the
815 county and judicial district of residence of the licensee,
816 registrant or permit holder, or if the licensee, registrant or
817 permit holder is a nonresident of the State of Mississippi, in the
818 Chancery Court of the First Judicial District of Hinds County,
819 Mississippi. When those proceedings are instituted, the board
820 shall certify the record of its proceedings, together with all
821 documents and evidence, to the chancery court and the matter shall
822 be heard in due course by the court, which shall review the record
823 and make its determination thereon in accordance with the
824 provisions of Section 73-21-101. The hearing on the matter may,
825 in the discretion of the chancellor, be tried in vacation.
826 (4) The board shall develop and implement a uniform penalty
827 policy that sets the minimum and maximum penalty for any given
828 violation of board regulations and laws governing the practice of
829 pharmacy. The board shall adhere to its uniform penalty policy
830 except in those cases where the board specifically finds, by
831 majority vote, that a penalty in excess of, or less than, the

832 uniform penalty is appropriate. That vote shall be reflected in
833 the minutes of the board and shall not be imposed unless it
834 appears as having been adopted by the board.
835 **SECTION 17.** This act shall take effect and be in force from
836 and after July 1, 2023.

ST: Pharmacy benefit managers; require to make available to the public, without redaction, contracts relating to pharmacy benefit