MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representative Yancey To: Insurance

HOUSE BILL NO. 1299
(As Passed the House)

1 AN ACT TO REQUIRE PHARMACY BENEFIT MANAGERS TO MAKE AVAILABLE
2 TO THE PUBLIC UPON REQUEST, AND WITHOUT REDACTION, THIRD PARTY
3 AGGREGATOR CONTRACTS AND CONTRACTS RELATING TO PHARMACY BENEFIT
4 MANAGEMENT SERVICES BETWEEN A PHARMACY BENEFIT MANAGER AND ANY
5 ENTITY, AND CONTRACTS WITH PHARMACY SERVICES ADMINISTRATIVE
6 ORGANIZATIONS; TO PROVIDE THAT ONLY THOSE CONTRACTS WHERE THE
7 STATE OF MISSISSIPPI OR A POLITICAL SUBDIVISION OF THE STATE IS A
8 PARTY TO THE THIRD PARTY AGGREGATOR CONTRACT OR THE CONTRACT
9 RELATING TO PHARMACY BENEFIT MANAGEMENT SERVICES OR WITH A
10 PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION SHALL BE REQUIRED TO
11 BE MADE PUBLIC; TO AMEND SECTION 73-21-153, MISSISSIPPI CODE OF
12 1972, TO REMOVE THE EXEMPTION FOR THE MISSISSIPPI STATE AND SCHOOL
13 EMPLOYEES HEALTH INSURANCE PLAN AND THE MISSISSIPPI DIVISION OF
14 MEDICAID OR ITS CONTRACTORS WHEN PERFORMING PHARMACY BENEFIT
15 MANAGER SERVICES FOR THE DIVISION OF MEDICAID IN THE DEFINITION OF
16 "PHARMACY BENEFIT MANAGER"; TO BRING FORWARD SECTIONS 73-21-155,
17 73-21-156, 73-21-157, 73-21-159, 73-21-161 AND 73-21-163,
18 MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE PHARMACY BENEFIT
19 PROMPT PAY ACT, FOR PURPOSES OF POSSIBLE AMENDMENT; TO BRING
20 FORWARD SECTIONS 73-21-177, 73-21-179, 73-21-181, 73-21-183,
21 73-21-185, 73-21-187, 73-21-189 AND 73-21-191, MISSISSIPPI CODE OF
22 1972, WHICH RELATE TO THE PHARMACY AUDIT INTEGRITY ACT, FOR
23 PURPOSES OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

25 **SECTION 1.** Notwithstanding any law to the contrary, a
26 pharmacy benefit manager shall make available to the public upon
27 request, and without redaction, third party aggregator contracts
28 and contracts relating to pharmacy benefit management services

29 between a pharmacy benefit manager and any entity, and contracts
30 with pharmacy services administrative organizations, at the
31 beginning of the term of the contract and upon renewal of the
32 contract. The provisions of this section shall only apply to
33 those contracts where the State of Mississippi or a political
34 subdivision of the state is a party to the third party aggregator
35 contract or the contract relating to pharmacy benefit management
36 services or with a pharmacy services administrative organization.
37 **SECTION 2.** Section 73-21-153, Mississippi Code of 1972, is
38 amended as follows:
39 73-21-153. For purposes of Sections 73-21-151 through
40 73-21-163, the following words and phrases shall have the meanings
41 ascribed herein unless the context clearly indicates otherwise:
42 (a) "Board" means the State Board of Pharmacy.
43 (b) "Commissioner" means the Mississippi Commissioner
44 of Insurance.
45 (c) "Day" means a calendar day, unless otherwise
46 defined or limited.
47 (d) "Electronic claim" means the transmission of data
48 for purposes of payment of covered prescription drugs, other
49 products and supplies, and pharmacist services in an electronic
50 data format specified by a pharmacy benefit manager and approved
51 by the department.

52 (e) "Electronic adjudication" means the process of
53 electronically receiving, reviewing and accepting or rejecting an
54 electronic claim.
55 (f) "Enrollee" means an individual who has been
56 enrolled in a pharmacy benefit management plan.
57 (g) "Health insurance plan" means benefits consisting
58 of prescription drugs, other products and supplies, and pharmacist
59 services provided directly, through insurance or reimbursement, or
60 otherwise and including items and services paid for as
61 prescription drugs, other products and supplies, and pharmacist
62 services under any hospital or medical service policy or
63 certificate, hospital or medical service plan contract, preferred
64 provider organization agreement, or health maintenance
65 organization contract offered by a health insurance issuer.
66 (h) "Pharmacy benefit manager" shall have the same
67 definition as provided in Section 73-21-179. However, through
68 June 30, 2014, the term "pharmacy benefit manager" shall not
69 include an insurance company that provides an integrated health
70 benefit plan and that does not separately contract for pharmacy
71 benefit management services. From and after July 1, 2014, the
72 term "pharmacy benefit manager" shall not include an insurance
73 company unless the insurance company is providing services as a
74 pharmacy benefit manager as defined in Section 73-21-179, in which
75 case the insurance company shall be subject to Sections 73-21-151

76 through 73-21-159 only for those pharmacy benefit manager
77 services. * * *
78 (i) "Pharmacy benefit manager affiliate" means a
79 pharmacy or pharmacist that directly or indirectly, through one or
80 more intermediaries, owns or controls, is owned or controlled by,
81 or is under common ownership or control with a pharmacy benefit
82 manager.
83 (j) "Pharmacy benefit management plan" shall have the
84 same definition as provided in Section 73-21-179.
85 (k) "Pharmacist," "pharmacist services" and "pharmacy"
86 or "pharmacies" shall have the same definitions as provided in
87 Section 73-21-73.
88 (l) "Uniform claim form" means a form prescribed by
89 rule by the State Board of Pharmacy; however, for purposes of
90 Sections 73-21-151 through 73-21-159, the board shall adopt the
91 same definition or rule where the State Department of Insurance
92 has adopted a rule covering the same type of claim. The board may
93 modify the terminology of the rule and form when necessary to
94 comply with the provisions of Sections 73-21-151 through
95 73-21-159.
96 (m) "Plan sponsors" means the employers, insurance
97 companies, unions and health maintenance organizations that
98 contract with a pharmacy benefit manager for delivery of
99 prescription services.

100 **SECTION 3.** Section 73-21-155, Mississippi Code of 1972, is
101 brought forward as follows:
102 73-21-155. (1) Reimbursement under a contract to a
103 pharmacist or pharmacy for prescription drugs and other products
104 and supplies that is calculated according to a formula that uses
105 Medi-Span, Gold Standard or a nationally recognized reference that
106 has been approved by the board in the pricing calculation shall
107 use the most current reference price or amount in the actual or
108 constructive possession of the pharmacy benefit manager, its
109 agent, or any other party responsible for reimbursement for
110 prescription drugs and other products and supplies on the date of
111 electronic adjudication or on the date of service shown on the
112 nonelectronic claim.
113 (2) Pharmacy benefit managers, their agents and other
114 parties responsible for reimbursement for prescription drugs and
115 other products and supplies shall be required to update the
116 nationally recognized reference prices or amounts used for
117 calculation of reimbursement for prescription drugs and other
118 products and supplies no less than every three (3) business days.
119 (3) (a) All benefits payable under a pharmacy benefit
120 management plan shall be paid within seven (7) days after receipt
121 of due written proof of a clean claim where claims are submitted
122 electronically, and shall be paid within thirty-five (35) days
123 after receipt of due written proof of a clean claim where claims
124 are submitted in paper format. Benefits due under the plan and

125 claims are overdue if not paid within seven (7) days or
126 thirty-five (35) days, whichever is applicable, after the pharmacy
127 benefit manager receives a clean claim containing necessary
128 information essential for the pharmacy benefit manager to
129 administer preexisting condition, coordination of benefits and
130 subrogation provisions under the plan sponsor's health insurance
131 plan. A "clean claim" means a claim received by any pharmacy
132 benefit manager for adjudication and which requires no further
133 information, adjustment or alteration by the pharmacist or
134 pharmacies or the insured in order to be processed and paid by the
135 pharmacy benefit manager. A claim is clean if it has no defect or
136 impropriety, including any lack of substantiating documentation,
137 or particular circumstance requiring special treatment that
138 prevents timely payment from being made on the claim under this
139 subsection. A clean claim includes resubmitted claims with
140 previously identified deficiencies corrected.
141 (b) A clean claim does not include any of the
142 following:
143 (i) A duplicate claim, which means an original
144 claim and its duplicate when the duplicate is filed within thirty
145 (30) days of the original claim;
146 (ii) Claims which are submitted fraudulently or
147 that are based upon material misrepresentations;
148 (iii) Claims that require information essential
149 for the pharmacy benefit manager to administer preexisting

150 condition, coordination of benefits or subrogation provisions
151 under the plan sponsor's health insurance plan; or
152 (iv) Claims submitted by a pharmacist or pharmacy
153 more than thirty (30) days after the date of service; if the
154 pharmacist or pharmacy does not submit the claim on behalf of the
155 insured, then a claim is not clean when submitted more than thirty
156 (30) days after the date of billing by the pharmacist or pharmacy
157 to the insured.
158 (c) Not later than seven (7) days after the date the
159 pharmacy benefit manager actually receives an electronic claim,
160 the pharmacy benefit manager shall pay the appropriate benefit in
161 full, or any portion of the claim that is clean, and notify the
162 pharmacist or pharmacy (where the claim is owed to the pharmacist
163 or pharmacy) of the reasons why the claim or portion thereof is
164 not clean and will not be paid and what substantiating
165 documentation and information is required to adjudicate the claim
166 as clean. Not later than thirty-five (35) days after the date the
167 pharmacy benefit manager actually receives a paper claim, the
168 pharmacy benefit manager shall pay the appropriate benefit in
169 full, or any portion of the claim that is clean, and notify the
170 pharmacist or pharmacy (where the claim is owed to the pharmacist
171 or pharmacy) of the reasons why the claim or portion thereof is
172 not clean and will not be paid and what substantiating
173 documentation and information is required to adjudicate the claim
174 as clean. Any claim or portion thereof resubmitted with the

175 supporting documentation and information requested by the pharmacy
176 benefit manager shall be paid within twenty (20) days after
177 receipt.
178 (4) If the board finds that any pharmacy benefit manager,
179 agent or other party responsible for reimbursement for
180 prescription drugs and other products and supplies has not paid
181 ninety-five percent (95%) of clean claims as defined in subsection
182 (3) of this section received from all pharmacies in a calendar
183 quarter, he shall be subject to administrative penalty of not more
184 than Twenty-five Thousand Dollars ($25,000.00) to be assessed by
185 the State Board of Pharmacy.
186 (a) Examinations to determine compliance with this
187 subsection may be conducted by the board. The board may contract
188 with qualified impartial outside sources to assist in examinations
189 to determine compliance. The expenses of any such examinations
190 shall be paid by the pharmacy benefit manager examined.
191 (b) Nothing in the provisions of this section shall
192 require a pharmacy benefit manager to pay claims that are not
193 covered under the terms of a contract or policy of accident and
194 sickness insurance or prepaid coverage.
195 (c) If the claim is not denied for valid and proper
196 reasons by the end of the applicable time period prescribed in
197 this provision, the pharmacy benefit manager must pay the pharmacy
198 (where the claim is owed to the pharmacy) or the patient (where
199 the claim is owed to a patient) interest on accrued benefits at

200 the rate of one and one-half percent (1-1/2%) per month accruing
201 from the day after payment was due on the amount of the benefits
202 that remain unpaid until the claim is finally settled or
203 adjudicated. Whenever interest due pursuant to this provision is
204 less than One Dollar ($1.00), such amount shall be credited to the
205 account of the person or entity to whom such amount is owed.
206 (d) Any pharmacy benefit manager and a pharmacy may
207 enter into an express written agreement containing timely claim
208 payment provisions which differ from, but are at least as
209 stringent as, the provisions set forth under subsection (3) of
210 this section, and in such case, the provisions of the written
211 agreement shall govern the timely payment of claims by the
212 pharmacy benefit manager to the pharmacy. If the express written
213 agreement is silent as to any interest penalty where claims are
214 not paid in accordance with the agreement, the interest penalty
215 provision of subsection (4)(c) of this section shall apply.
216 (e) The State Board of Pharmacy may adopt rules and
217 regulations necessary to ensure compliance with this subsection.
218 (5) (a) For purposes of this subsection (5), "network
219 pharmacy" means a licensed pharmacy in this state that has a
220 contract with a pharmacy benefit manager to provide covered drugs
221 at a negotiated reimbursement rate. A network pharmacy or
222 pharmacist may decline to provide a brand name drug, multisource
223 generic drug, or service, if the network pharmacy or pharmacist is
224 paid less than that network pharmacy's acquisition cost for the

225 product. If the network pharmacy or pharmacist declines to
226 provide such drug or service, the pharmacy or pharmacist shall
227 provide the customer with adequate information as to where the
228 prescription for the drug or service may be filled.
229 (b) The State Board of Pharmacy shall adopt rules and
230 regulations necessary to implement and ensure compliance with this
231 subsection, including, but not limited to, rules and regulations
232 that address access to pharmacy services in rural or underserved
233 areas in cases where a network pharmacy or pharmacist declines to
234 provide a drug or service under paragraph (a) of this subsection.
235 The board shall promulgate the rules and regulations required by
236 this paragraph (b) not later than October 1, 2016.
237 (6) A pharmacy benefit manager shall not directly or
238 indirectly retroactively deny or reduce a claim or aggregate of
239 claims after the claim or aggregate of claims has been
240 adjudicated.
241 **SECTION 4.** Section 73-21-156, Mississippi Code of 1972, is
242 brought forward as follows:
243 73-21-156. (1) As used in this section, the following terms
244 shall be defined as provided in this subsection:
245 (a) "Maximum allowable cost list" means a listing of
246 drugs or other methodology used by a pharmacy benefit manager,
247 directly or indirectly, setting the maximum allowable payment to a
248 pharmacy or pharmacist for a generic drug, brand-name drug,

249 biologic product or other prescription drug. The term "maximum
250 allowable cost list" includes without limitation:
251 (i) Average acquisition cost, including national
252 average drug acquisition cost;
253 (ii) Average manufacturer price;
254 (iii) Average wholesale price;
255 (iv) Brand effective rate or generic effective
256 rate;
257 (v) Discount indexing;
258 (vi) Federal upper limits;
259 (vii) Wholesale acquisition cost; and
260 (viii) Any other term that a pharmacy benefit
261 manager or a health care insurer may use to establish
262 reimbursement rates to a pharmacist or pharmacy for pharmacist
263 services.
264 (b) "Pharmacy acquisition cost" means the amount that a
265 pharmaceutical wholesaler charges for a pharmaceutical product as
266 listed on the pharmacy's billing invoice.
267 (2) Before a pharmacy benefit manager places or continues a
268 particular drug on a maximum allowable cost list, the drug:
269 (a) If the drug is a generic equivalent drug product as
270 defined in 73-21-73, shall be listed as therapeutically equivalent
271 and pharmaceutically equivalent "A" or "B" rated in the United
272 States Food and Drug Administration's most recent version of the
273 "Orange Book" or "Green Book" or have an NR or NA rating by

274 Medi-Span, Gold Standard, or a similar rating by a nationally
275 recognized reference approved by the board;
276 (b) Shall be available for purchase by each pharmacy in
277 the state from national or regional wholesalers operating in
278 Mississippi; and
279 (c) Shall not be obsolete.
280 (3) A pharmacy benefit manager shall:
281 (a) Provide access to its maximum allowable cost list
282 to each pharmacy subject to the maximum allowable cost list;
283 (b) Update its maximum allowable cost list on a timely
284 basis, but in no event longer than three (3) calendar days; and
285 (c) Provide a process for each pharmacy subject to the
286 maximum allowable cost list to receive prompt notification of an
287 update to the maximum allowable cost list.
288 (4) A pharmacy benefit manager shall:
289 (a) Provide a reasonable administrative appeal
290 procedure to allow pharmacies to challenge a maximum allowable
291 cost list and reimbursements made under a maximum allowable cost
292 list for a specific drug or drugs as:
293 (i) Not meeting the requirements of this section;
294 or
295 (ii) Being below the pharmacy acquisition cost.
296 (b) The reasonable administrative appeal procedure
297 shall include the following:

298 (i) A dedicated telephone number, email address
299 and website for the purpose of submitting administrative appeals;
300 (ii) The ability to submit an administrative
301 appeal directly to the pharmacy benefit manager regarding the
302 pharmacy benefit management plan or through a pharmacy service
303 administrative organization; and
304 (iii) A period of less than thirty (30) business
305 days to file an administrative appeal.
306 (c) The pharmacy benefit manager shall respond to the
307 challenge under paragraph (a) of this subsection (4) within thirty
308 (30) business days after receipt of the challenge.
309 (d) If a challenge is made under paragraph (a) of this
310 subsection (4), the pharmacy benefit manager shall within thirty
311 (30) business days after receipt of the challenge either:
312 (i) If the appeal is upheld:
313 1. Make the change in the maximum allowable
314 cost list payment to at least the pharmacy acquisition cost;
315 2. Permit the challenging pharmacy or
316 pharmacist to reverse and rebill the claim in question;
317 3. Provide the National Drug Code that the
318 increase or change is based on to the pharmacy or pharmacist; and
319 4. Make the change under item 1 of this
320 subparagraph (i) effective for each similarly situated pharmacy as
321 defined by the payor subject to the maximum allowable cost list;
322 or

323 (ii) If the appeal is denied, provide the
324 challenging pharmacy or pharmacist the National Drug Code and the
325 name of the national or regional pharmaceutical wholesalers
326 operating in Mississippi that have the drug currently in stock at
327 a price below the maximum allowable cost as listed on the maximum
328 allowable cost list; or

329 (iii) If the National Drug Code provided by the
330 pharmacy benefit manager is not available below the pharmacy
331 acquisition cost from the pharmaceutical wholesaler from whom the
332 pharmacy or pharmacist purchases the majority of prescription
333 drugs for resale, then the pharmacy benefit manager shall adjust
334 the maximum allowable cost as listed on the maximum allowable cost
335 list above the challenging pharmacy's pharmacy acquisition cost
336 and permit the pharmacy to reverse and rebill each claim affected
337 by the inability to procure the drug at a cost that is equal to or
338 less than the previously challenged maximum allowable cost.

339 (5) (a) A pharmacy benefit manager shall not reimburse a
340 pharmacy or pharmacist in the state an amount less than the amount
341 that the pharmacy benefit manager reimburses a pharmacy benefit
342 manager affiliate for providing the same pharmacist services.

343 (b) The amount shall be calculated on a per unit basis
344 based on the same brand and generic product identifier or brand
345 and generic code number.

346 **SECTION 5.** Section 73-21-157, Mississippi Code of 1972, is
347 brought forward as follows:

348 73-21-157. (1) Before beginning to do business as a
349 pharmacy benefit manager, a pharmacy benefit manager shall obtain
350 a license to do business from the board. To obtain a license, the
351 applicant shall submit an application to the board on a form to be
352 prescribed by the board.

353 (2) Each pharmacy benefit manager providing pharmacy
354 management benefit plans in this state shall file a statement with
355 the board annually by March 1 or within sixty (60) days of the end
356 of its fiscal year if not a calendar year. The statement shall be
357 verified by at least two (2) principal officers and shall cover
358 the preceding calendar year or the immediately preceding fiscal
359 year of the pharmacy benefit manager.

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

362 (a) A financial statement of the organization,
363 including its balance sheet and income statement for the preceding
364 year; and

365 (b) Any other information relating to the operations of
366 the pharmacy benefit manager required by the board under this
367 section.

368 (4) (a) Any information required to be submitted to the
369 board pursuant to licensure application that is considered
370 proprietary by a pharmacy benefit manager shall be marked as
371 confidential when submitted to the board. All such information
372 shall not be subject to the provisions of the federal Freedom of

373 Information Act or the Mississippi Public Records Act and shall
374 not be released by the board unless subject to an order from a
375 court of competent jurisdiction. The board shall destroy or
376 delete or cause to be destroyed or deleted all such information
377 thirty (30) days after the board determines that the information
378 is no longer necessary or useful.

379 (b) Any person who knowingly releases, causes to be
380 released or assists in the release of any such information shall
381 be subject to a monetary penalty imposed by the board in an amount
382 not exceeding Fifty Thousand Dollars ($50,000.00) per violation.
383 When the board is considering the imposition of any penalty under
384 this paragraph (b), it shall follow the same policies and
385 procedures provided for the imposition of other sanctions in the
386 Pharmacy Practice Act. Any penalty collected under this paragraph
387 (b) shall be deposited into the special fund of the board and used
388 to support the operations of the board relating to the regulation
389 of pharmacy benefit managers.

390 (c) All employees of the board who have access to the
391 information described in paragraph (a) of this subsection shall be
392 fingerprinted, and the board shall submit a set of fingerprints
393 for each employee to the Department of Public Safety for the
394 purpose of conducting a criminal history records check. If no
395 disqualifying record is identified at the state level, the
396 Department of Public Safety shall forward the fingerprints to the

397 Federal Bureau of Investigation for a national criminal history
398 records check.
399 (5) If the pharmacy benefit manager is audited annually by
400 an independent certified public accountant, a copy of the
401 certified audit report shall be filed annually with the board by
402 June 30 or within thirty (30) days of the report being final.
403 (6) The board may extend the time prescribed for any
404 pharmacy benefit manager for filing annual statements or other
405 reports or exhibits of any kind for good cause shown. However,
406 the board shall not extend the time for filing annual statements
407 beyond sixty (60) days after the time prescribed by subsection (1)
408 of this section. The board may waive the requirements for filing
409 financial information for the pharmacy benefit manager if an
410 affiliate of the pharmacy benefit manager is already required to
411 file such information under current law with the Commissioner of
412 Insurance and allow the pharmacy benefit manager to file a copy of
413 documents containing such information with the board in lieu of
414 the statement required by this section.
415 (7) The expense of administering this section shall be
416 assessed annually by the board against all pharmacy benefit
417 managers operating in this state.
418 (8) A pharmacy benefit manager or third-party payor may not
419 require pharmacy accreditation standards or recertification
420 requirements inconsistent with, more stringent than, or in

421 addition to federal and state requirements for licensure as a
422 pharmacy in this state.

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

425 73-21-159. (1) In lieu of or in addition to making its own
426 financial examination of a pharmacy benefit manager, the board may
427 accept the report of a financial examination of other persons
428 responsible for the pharmacy benefit manager under the laws of
429 another state certified by the applicable official of such other
430 state.

431 (2) The board shall coordinate financial examinations of a
432 pharmacy benefit manager that provides pharmacy management benefit
433 plans in this state to ensure an appropriate level of regulatory
434 oversight and to avoid any undue duplication of effort or
435 regulation. The pharmacy benefit manager being examined shall pay
436 the cost of the examination. The cost of the examination shall be
437 deposited in a special fund that shall provide all expenses for
438 the licensing, supervision and examination of all pharmacy benefit
439 managers subject to regulation under Sections 73-21-71 through
440 73-21-129 and Sections 73-21-151 through 73-21-163.

441 (3) The board may provide a copy of the financial
442 examination to the person or entity who provides or operates the
443 health insurance plan or to a pharmacist or pharmacy.

444 (4) The board is authorized to hire independent financial
445 consultants to conduct financial examinations of a pharmacy

446 benefit manager and to expend funds collected under this section
447 to pay the costs of such examinations.

448 **SECTION 7.** Section 73-21-161, Mississippi Code of 1972, is
449 brought forward as follows:

450 73-21-161. (1) As used in this section, the term "referral"
451 means:

452 (a) Ordering of a patient to a pharmacy by a pharmacy
453 benefit manager affiliate either orally or in writing, including
454 online messaging;

455 (b) Offering or implementing plan designs that require
456 patients to use affiliated pharmacies; or

457 (c) Patient or prospective patient specific
458 advertising, marketing, or promotion of a pharmacy by an
459 affiliate.

460 The term "referral" does not include a pharmacy's inclusion
461 by a pharmacy benefit manager affiliate in communications to
462 patients, including patient and prospective patient specific
463 communications, regarding network pharmacies and prices, provided
464 that the affiliate includes information regarding eligible
465 nonaffiliate pharmacies in those communications and the
466 information provided is accurate.

467 (2) A pharmacy, pharmacy benefit manager, or pharmacy
468 benefit manager affiliate licensed or operating in Mississippi
469 shall be prohibited from:

470 (a) Making referrals;

471 (b) Transferring or sharing records relative to
472 prescription information containing patient identifiable and
473 prescriber identifiable data to or from a pharmacy benefit manager
474 affiliate for any commercial purpose; however, nothing in this
475 section shall be construed to prohibit the exchange of
476 prescription information between a pharmacy and its affiliate for
477 the limited purposes of pharmacy reimbursement; formulary
478 compliance; pharmacy care; public health activities otherwise
479 authorized by law; or utilization review by a health care
480 provider; or
481 (c) Presenting a claim for payment to any individual,
482 third-party payor, affiliate, or other entity for a service
483 furnished pursuant to a referral from an affiliate.
484 (3) This section shall not be construed to prohibit a
485 pharmacy from entering into an agreement with a pharmacy benefit
486 manager affiliate to provide pharmacy care to patients, provided
487 that the pharmacy does not receive referrals in violation of
488 subsection (2) of this section and the pharmacy provides the
489 disclosures required in subsection (1) of this section.
490 (4) If a pharmacy licensed or holding a nonresident pharmacy
491 permit in this state has an affiliate, it shall annually file with
492 the board a disclosure statement identifying all such affiliates.
493 (5) In addition to any other remedy provided by law, a
494 violation of this section by a pharmacy shall be grounds for

495 disciplinary action by the board under its authority granted in
496 this chapter.
497 (6) A pharmacist who fills a prescription that violates
498 subsection (2) of this section shall not be liable under this
499 section.
500 **SECTION 8.** Section 73-21-163, Mississippi Code of 1972, is
501 brought forward as follows:
502 73-21-163. Whenever the board has reason to believe that a
503 pharmacy benefit manager or pharmacy benefit manager affiliate is
504 using, has used, or is about to use any method, act or practice
505 prohibited in Sections 73-21-151 through 73-21-163 and that
506 proceedings would be in the public interest, it may bring an
507 action in the name of the board against the pharmacy benefit
508 manager or pharmacy benefit manager affiliate to restrain by
509 temporary or permanent injunction the use of such method, act or
510 practice. The action shall be brought in the Chancery Court of
511 the First Judicial District of Hinds County, Mississippi. The
512 court is authorized to issue temporary or permanent injunctions to
513 restrain and prevent violations of Sections 73-21-151 through
514 73-21-163 and such injunctions shall be issued without bond.
515 (2) The board may impose a monetary penalty on a pharmacy
516 benefit manager or a pharmacy benefit manager affiliate for
517 noncompliance with the provisions of the Sections 73-21-151
518 through 73-21-163, in amounts of not less than One Thousand
519 Dollars ($1,000.00) per violation and not more than Twenty-five

520 Thousand Dollars ($25,000.00) per violation. Each day a violation
521 continues for the same brand or generic product identifier or
522 brand or generic code number is a separate violation. The board
523 shall prepare a record entered upon its minutes that states the
524 basic facts upon which the monetary penalty was imposed. Any
525 penalty collected under this subsection (2) shall be deposited
526 into the special fund of the board.
527 (3) The board may assess a monetary penalty for those
528 reasonable costs that are expended by the board in the
529 investigation and conduct of a proceeding if the board imposes a
530 monetary penalty under subsection (2) of this section. A monetary
531 penalty assessed and levied under this section shall be paid to
532 the board by the licensee, registrant or permit holder upon the
533 expiration of the period allowed for appeal of those penalties
534 under Section 73-21-101, or may be paid sooner if the licensee,
535 registrant or permit holder elects. Any penalty collected by the
536 board under this subsection (3) shall be deposited into the
537 special fund of the board.
538 (4) When payment of a monetary penalty assessed and levied
539 by the board against a licensee, registrant or permit holder in
540 accordance with this section is not paid by the licensee,
541 registrant or permit holder when due under this section, the board
542 shall have the power to institute and maintain proceedings in its
543 name for enforcement of payment in the chancery court of the
544 county and judicial district of residence of the licensee,

545 registrant or permit holder, or if the licensee, registrant or
546 permit holder is a nonresident of the State of Mississippi, in the
547 Chancery Court of the First Judicial District of Hinds County,
548 Mississippi. When those proceedings are instituted, the board
549 shall certify the record of its proceedings, together with all
550 documents and evidence, to the chancery court and the matter shall
551 be heard in due course by the court, which shall review the record
552 and make its determination thereon in accordance with the
553 provisions of Section 73-21-101. The hearing on the matter may,
554 in the discretion of the chancellor, be tried in vacation.

555 (5) The board shall develop and implement a uniform penalty
556 policy that sets the minimum and maximum penalty for any given
557 violation of Sections 73-21-151 through 73-21-163. The board
558 shall adhere to its uniform penalty policy except in those cases
559 where the board specifically finds, by majority vote, that a
560 penalty in excess of, or less than, the uniform penalty is
561 appropriate. That vote shall be reflected in the minutes of the
562 board and shall not be imposed unless it appears as having been
563 adopted by the board.

564 **SECTION 9**. Section 73-21-177, Mississippi Code of 1972, is
565 brought forward as follows:

566 73-21-177. The purpose of Sections 73-21-175 through
567 73-21-189 is to establish minimum and uniform standards and
568 criteria for the audit of pharmacy records by or on behalf of
569 certain entities.

570 **SECTION 10.** Section 73-21-179, Mississippi Code of 1972, is
571 brought forward as follows:
572 73-21-179. For purposes of Sections 73-21-175 through
573 73-21-189:
574 (a) "Entity" means a pharmacy benefit manager, a
575 managed care company, a health plan sponsor, an insurance company,
576 a third-party payor, or any company, group or agent that
577 represents or is engaged by those entities.
578 (b) "Health insurance plan" means benefits consisting
579 of prescription drugs, other products and supplies, and pharmacist
580 services provided directly, through insurance or reimbursement, or
581 otherwise and including items and services paid for as
582 prescription drugs, other products and supplies, and pharmacist
583 services under any hospital or medical service policy or
584 certificate, hospital or medical service plan contract, preferred
585 provider organization agreement, or health maintenance
586 organization contract offered by a health insurance
587 issuer.
588 (c) "Individual prescription" means the original
589 prescription for a drug signed by the prescriber, and excludes
590 refills referenced on the prescription.
591 (d) "Pharmacy benefit manager" means a business that
592 administers the prescription drug/device portion of pharmacy
593 benefit management plans or health insurance plans on behalf of
594 plan sponsors, insurance companies, unions and health maintenance

595 organizations. Pharmacy benefit managers may also provide some,
596 all, but may not be limited to, the following services either
597 directly or through outsourcing or contracts with other entities:
598 (i) Adjudicate drug claims or any portion of the
599 transaction.
600 (ii) Contract with retail and mail pharmacy
601 networks.
602 (iii) Establish payment levels for pharmacies.
603 (iv) Develop formulary or drug list of covered
604 therapies.
605 (v) Provide benefit design consultation.
606 (vi) Manage cost and utilization trends.
607 (vii) Contract for manufacturer rebates.
608 (viii) Provide fee-based clinical services to
609 improve member care.
610 (ix) Third-party administration.
611 (e) "Pharmacy benefit management plan" means an
612 arrangement for the delivery of pharmacist's services in which a
613 pharmacy benefit manager undertakes to administer the payment or
614 reimbursement of any of the costs of pharmacist's services for an
615 enrollee on a prepaid or insured basis that (i) contains one or
616 more incentive arrangements intended to influence the cost or
617 level of pharmacist's services between the plan sponsor and one or
618 more pharmacies with respect to the delivery of pharmacist's
619 services; and (ii) requires or creates benefit payment

620 differential incentives for enrollees to use under contract with
621 the pharmacy benefit manager.

622 (f) "Pharmacist," "pharmacist services" and "pharmacy"
623 or "pharmacies" shall have the same definitions as provided in
624 Section 73-21-73.

625 **SECTION 11.** Section 73-21-181, Mississippi Code of 1972, is
626 brought forward as follows:

627 73-21-181. Sections 73-21-175 through 73-21-189 shall apply
628 to any audit of the records of a pharmacy conducted by a managed
629 care company, nonprofit hospital or medical service organization,
630 insurance company, third-party payor, pharmacy benefit manager, a
631 health program administered by a department of the state or any
632 entity that represents those companies, groups, or department.

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

635 73-21-183. (1) The entity conducting an audit shall follow
636 these procedures:

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

639 (b) The entity conducting the on-site audit must give
640 the pharmacy written notice at least two (2) weeks before
641 conducting the initial on-site audit for each audit cycle, and the
642 pharmacy shall have at least fourteen (14) days to respond to any
643 desk audit requirements;

644 (c) The entity conducting the on-site or desk audit
645 shall not interfere with the delivery of pharmacist services to a
646 patient and shall utilize every effort to minimize inconvenience
647 and disruption to pharmacy operations during the audit process;
648 (d) Any audit that involves clinical or professional
649 judgment must be conducted by or in consultation with a
650 pharmacist;
651 (e) Any clerical or record-keeping error, such as a
652 typographical error, scrivener's error, or computer error,
653 regarding a required document or record shall not constitute
654 fraud; however, those claims may be subject to recoupment. No
655 such claim shall be subject to criminal penalties without proof of
656 intent to commit fraud;
657 (f) A pharmacy may use the records of a hospital,
658 physician, or other authorized practitioner of the healing arts
659 for drugs or medicinal supplies written or transmitted by any
660 means of communication for purposes of validating the pharmacy
661 record with respect to orders or refills of a legend or narcotic
662 drug;
663 (g) A finding of an overpayment or an underpayment may
664 be a projection based on the number of patients served having a
665 similar diagnosis or on the number of similar orders or refills
666 for similar drugs, except that recoupment shall be based on the
667 actual overpayment or underpayment;

668 (h) A finding of an overpayment shall not include the
669 dispensing fee amount unless a prescription was not dispensed;
670 (i) Each pharmacy shall be audited under the same
671 standards and parameters as other similarly situated pharmacies
672 audited by the entity;
673 (j) The period covered by an audit may not exceed two
674 (2) years from the date the claim was submitted to or adjudicated
675 by a managed care company, nonprofit hospital or medical service
676 organization, insurance company, third-party payor, pharmacy
677 benefit manager, a health program administered by a department of
678 the state or any entity that represents those companies, groups,
679 or department;
680 (k) An audit may not be initiated or scheduled during
681 the first five (5) calendar days of any month due to the high
682 volume of prescriptions filled in the pharmacy during that time
683 unless otherwise consented to by the pharmacy;
684 (l) Any prescription that complies with state law and
685 rule requirements may be used to validate claims in connection
686 with prescriptions, refills or changes in prescriptions;
687 (m) An exit interview that provides a pharmacy with an
688 opportunity to respond to questions and comment on and clarify
689 findings must be conducted at the end of an audit. The time of
690 the interview must be agreed to by the pharmacy;
691 (n) Unless superseded by state or federal law, auditors
692 shall only have access to previous audit reports on a particular

693 pharmacy conducted by the auditing entity for the same pharmacy
694 benefits manager, health plan or insurer. An auditing vendor
695 contracting with multiple pharmacy benefits managers or health
696 insurance plans shall not use audit reports or other information
697 gained from an audit on a particular pharmacy to conduct another
698 audit for a different pharmacy benefits manager or health
699 insurance plan;
700 (o) The parameters of an audit must comply with
701 consumer-oriented parameters based on manufacturer listings or
702 recommendations for the following:
703 (i) The day supply for eyedrops must be calculated
704 so that the consumer pays only one (1) thirty-day copayment if the
705 bottle of eyedrops is intended by the manufacturer to be a
706 thirty-day supply;
707 (ii) The day supply for insulin must be calculated
708 so that the highest dose prescribed is used to determine the day
709 supply and consumer copayment;
710 (iii) The day supply for a topical product must be
711 determined by the judgment of the pharmacist based upon the
712 treated area;
713 (p) (i) Where an audit is for a specifically
714 identified problem that has been disclosed to the pharmacy, the
715 audit shall be limited to claims that are identified by
716 prescription number;

717 (ii) For an audit other than described in
718 subparagraph (i) of this paragraph (p), an audit shall be limited
719 to one hundred (100) individual prescriptions that have been
720 randomly selected;
721 (iii) If an audit reveals the necessity for a
722 review of additional claims, the audit shall be conducted on site;
723 (iv) Except for audits initiated under paragraph
724 (i) of this subsection, an entity shall not initiate an audit of a
725 pharmacy more than one (1) time in any quarter;
726 (r) A recoupment shall not be based on:
727 (i) Documentation requirements in addition to or
728 exceeding requirements for creating or maintaining documentation
729 prescribed by the State Board of Pharmacy; or
730 (ii) A requirement that a pharmacy or pharmacist
731 perform a professional duty in addition to or exceeding
732 professional duties prescribed by the State Board of Pharmacy;
733 (s) Except for Medicare claims, approval of drug,
734 prescriber or patient eligibility upon adjudication of a claim
735 shall not be reversed unless the pharmacy or pharmacist obtained
736 the adjudication by fraud or misrepresentation of claim elements;
737 and
738 (t) A commission or other payment to an agent or
739 employee of the entity conducting the audit is not based, directly
740 or indirectly, on amounts recouped.

741 (2) The entity must provide the pharmacy with a written
742 report of the audit and comply with the following requirements:
743 (a) The preliminary audit report must be delivered to
744 the pharmacy within one hundred twenty (120) days after conclusion
745 of the audit, with a reasonable extension to be granted upon
746 request;
747 (b) A pharmacy shall be allowed at least thirty (30)
748 days following receipt of the preliminary audit report in which to
749 produce documentation to address any discrepancy found during the
750 audit, with a reasonable extension to be granted upon request;
751 (c) A final audit report shall be delivered to the
752 pharmacy within one hundred eighty (180) days after receipt of the
753 preliminary audit report or final appeal, as provided for in
754 Section 73-21-185, whichever is later;
755 (d) The audit report must be signed by the auditor;
756 (e) Recoupments of any disputed funds, or repayment of
757 funds to the entity by the pharmacy if permitted pursuant to
758 contractual agreement, shall occur after final internal
759 disposition of the audit, including the appeals process as set
760 forth in Section 73-21-185. If the identified discrepancy for an
761 individual audit exceeds Twenty-five Thousand Dollars
762 ($25,000.00), future payments in excess of that amount to the
763 pharmacy may be withheld pending finalization of the audit;
764 (f) Interest shall not accrue during the audit period;
765 and

766 (g) Each entity conducting an audit shall provide a
767 copy of the final audit report, after completion of any review
768 process, to the plan sponsor.

769 **SECTION 13.** Section 73-21-185, Mississippi Code of 1972, is
770 brought forward as follows:

771 73-21-185. (1) Each entity conducting an audit shall
772 establish a written appeals process under which a pharmacy may
773 appeal an unfavorable preliminary audit report to the entity.

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

778 (3) If, following the appeal, any of the issues raised in
779 the appeal are not resolved to the satisfaction of either party,
780 that party may ask for mediation of those unresolved issues. A
781 certified mediator shall be chosen by agreement of the parties
782 from the Court Annexed Mediators List maintained by the
783 Mississippi Supreme Court.

784 **SECTION 14.** Section 73-21-187, Mississippi Code of 1972, is
785 brought forward as follows:

786 73-21-187. Notwithstanding any other provision in Sections
787 73-21-175 through 73-21-189, the entity conducting the audit shall
788 not use the accounting practice of extrapolation in calculating
789 recoupments or penalties for audits. An extrapolation audit means
790 an audit of a sample of prescription drug benefit claims submitted

791 by a pharmacy to the entity conducting the audit that is then used
792 to estimate audit results for a larger batch or group of claims
793 not reviewed by the auditor.

794 **SECTION 15.** Section 73-21-189, Mississippi Code of 1972, is
795 brought forward as follows:

796 73-21-189. Sections 73-21-175 through 73-21-189 do not apply
797 to any audit, review or investigation that involves alleged fraud,
798 willful misrepresentation or abuse.

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

801 73-21-191. (1) The State Board of Pharmacy may impose a
802 monetary penalty on pharmacy benefit managers for noncompliance
803 with the provisions of the Pharmacy Audit Integrity Act, Sections
804 73-21-175 through 73-21-189, in amounts of not less than One
805 Thousand Dollars ($1,000.00) per violation and not more than
806 Twenty-five Thousand Dollars ($25,000.00) per violation. The
807 board shall prepare a record entered upon its minutes which states
808 the basic facts upon which the monetary penalty was imposed. Any
809 penalty collected under this subsection (1) shall be deposited
810 into the special fund of the board.

811 (2) The board may assess a monetary penalty for those
812 reasonable costs that are expended by the board in the
813 investigation and conduct of a proceeding if the board imposes a
814 monetary penalty under subsection (1) of this section. A monetary
815 penalty assessed and levied under this section shall be paid to

816 the board by the licensee, registrant or permit holder upon the
817 expiration of the period allowed for appeal of those penalties
818 under Section 73-21-101, or may be paid sooner if the licensee,
819 registrant or permit holder elects. Money collected by the board
820 under this subsection (2) shall be deposited to the credit of the
821 special fund of the board.

822 (3) When payment of a monetary penalty assessed and levied
823 by the board against a licensee, registrant or permit holder in
824 accordance with this section is not paid by the licensee,
825 registrant or permit holder when due under this section, the board
826 shall have the power to institute and maintain proceedings in its
827 name for enforcement of payment in the chancery court of the
828 county and judicial district of residence of the licensee,
829 registrant or permit holder, or if the licensee, registrant or
830 permit holder is a nonresident of the State of Mississippi, in the
831 Chancery Court of the First Judicial District of Hinds County,
832 Mississippi. When those proceedings are instituted, the board
833 shall certify the record of its proceedings, together with all
834 documents and evidence, to the chancery court and the matter shall
835 be heard in due course by the court, which shall review the record
836 and make its determination thereon in accordance with the
837 provisions of Section 73-21-101. The hearing on the matter may,
838 in the discretion of the chancellor, be tried in vacation.

839 (4) The board shall develop and implement a uniform penalty
840 policy that sets the minimum and maximum penalty for any given

841 violation of board regulations and laws governing the practice of
842 pharmacy. The board shall adhere to its uniform penalty policy
843 except in those cases where the board specifically finds, by
844 majority vote, that a penalty in excess of, or less than, the
845 uniform penalty is appropriate. That vote shall be reflected in
846 the minutes of the board and shall not be imposed unless it
847 appears as having been adopted by the board.

848 **SECTION 17.** This act shall take effect and be in force from
849 and after July 1, 2023, and shall stand repealed on June 30, 2023.

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