By: Representatives White, Owen

To: State Affairs

HOUSE BILL NO. 1123

AN ACT TO PROHIBIT SPREAD PRICING; TO REQUIRE EACH DRUG MANUFACTURER TO SUBMIT A REPORT TO THE BOARD OF PHARMACY THAT INCLUDES THE CURRENT WHOLESALE ACQUISITION COST; TO REQUIRE SUCH ENTITIES TO PROVIDE THE BOARD OF PHARMACY WITH VARIOUS DRUG PRICING INFORMATION WITHIN A CERTAIN TIME; TO REQUIRE PHARMACY BENEFIT MANAGERS AND PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS TO FILE A REPORT WITH THE BOARD OF PHARMACY; TO REQUIRE EACH HEALTH INSURER TO SUBMIT A REPORT TO THE BOARD OF PHARMACY THAT INCLUDES CERTAIN DRUG PRESCRIPTION INFORMATION; TO REQUIRE THE BOARD OF PHARMACY TO DEVELOP A WEBSITE TO PUBLISH INFORMATION RELATED TO THE ACT; TO PROHIBIT PHARMACY BENEFIT MANAGERS AND PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS FROM RETALIATING AGAINST PHARMACISTS OR PHARMACIES FOR TAKING CERTAIN ACTIONS; TO AUTHORIZE THE BOARD OF PHARMACY TO CONDUCT INVESTIGATIONS, ISSUE SUBPOENAS, CONDUCT AUDITS AND IMPOSE A MONETARY PENALTY FOR VIOLATIONS RELATED TO THE ACT; TO REQUIRE PHARMACY BENEFIT MANAGERS AND PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS TO IDENTIFY OWNERSHIP AFFILIATION OF ANY KIND TO THE BOARD OF PHARMACY; TO BRING FORWARD SECTIONS 73-21-155, 73-21-156 AND 73-21-183, MISSISSIPPI CODE OF 1972, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. The following words and phrases shall have the meanings as defined in this section unless the context clearly indicates otherwise:

(a) "Board" means the Mississippi Board of Pharmacy.

(b) "Pharmacy services administrative organization" (PSAO) means an entity operating within the state that contracts with one or more independent pharmacies to conduct business on their behalf with third-party payers. PSAOs provide administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies. A person or entity is a PSAO for purposes of this act if it performs one or more of the following administrative services on behalf of one or more pharmacies, including, but not limited to:

(i) Assistance with claims;

(ii) Assistance with audits;

(iii) Assistance with access to pharmacy networks;

(iv) Assistance with interactions between the pharmacy and pharmacy benefit manager;

(v) Centralized payment;

(vi) Certification in specialized care programs;

(vii) Compliance support;

(viii) Setting flat fees for generic drugs;

(ix) Assistance with store layout;

(x) Marketing support;

(xi) Analysis of payment and drug dispensing data; or

(xii) Provision of resources for retail cash cards.

(c) "Proprietary information" means information on pricing, costs, revenue, taxes, market share, negotiating strategies, customers and personnel that is held by a pharmacy benefit manager or PSAO and used for its business purposes.

(d) "Spread pricing" means any amount charged or claimed by a pharmacy benefit manager or PSAO in excess of the ingredient cost for a dispensed prescription drug plus dispensing fee paid directly or indirectly to any pharmacy, pharmacist, or other provider on behalf of the health benefit plan, less a pharmacy benefit management or PSAO fee.

SECTION 2. (1) Except as otherwise provided in subsection (3), no pharmacy benefit manager, PSAO, carrier, or health benefit plan may, either directly or through an intermediary, agent, or affiliate engage in, facilitate, or enter into a contract with another person involving spread pricing in this state.

(2) A pharmacy benefit manager or PSAO contract with a carrier or health benefit plan entered into, renewed, or amended on or after the effective date of this act must:

(a) Specify all forms of revenue, including pharmacy benefit management or PSAO fees, to be paid by the carrier or health benefit plan to the pharmacy benefit manager or PSAO; and

(b) Acknowledge that spread pricing is not permitted in accordance with this section.

(3) The provisions of this section shall not apply to any self-funded health plans.

SECTION 3. (1) Each drug manufacturer shall submit a report to the Mississippi Board of Pharmacy no later than the fifteenth day of January, April, July, and October with the current wholesale acquisition cost information for the prescription drugs sold in or into the state by that drug manufacturer; provided, however, the first report due under this subsection shall not be due until October 1, 2025.

(2) Not more than thirty (30) days after an increase in wholesale acquisition cost of forty percent (40%) or greater over the preceding five (5) calendar years or ten percent (10%) or greater in the preceding twelve (12) months for a prescription drug with a wholesale acquisition cost of Seventy Dollars ($70.00) or more for a manufacturer-packaged drug container, a drug manufacturer shall submit a report to the board. The report must contain the following information:

(a) Name of the drug;

(b) Whether the drug is a brand name or a generic;

(c) The effective date of the change in wholesale acquisition cost;

(d) Aggregate, company-level research and development costs for the previous calendar year;

(e) Aggregate rebate amounts paid to each pharmacy benefit manager or PSAO for the previous calendar year;

(f) The name of each of the drug manufacturer's drugs approved by the United States Food and Drug Administration in the previous five (5) calendar years;

(g) The name of each of the drug manufacturer's drugs that lost patent exclusivity in the United States in the previous five (5) calendar years; and

(h) A concise statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost, such as raw ingredient shortage or increase in pharmacy benefit manager's or PSAO's rebates.

(2) The quality and types of information and data a drug manufacturer submits to the board pursuant to this section must be the same as the quality and types of information and data the drug manufacturer includes in the drug manufacturer's annual consolidated report on the Securities and Exchange Commission Form 10-K or any other public disclosure. A drug manufacturer shall notify the board in writing if the drug manufacturer is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D Program.

(3) The notice must include a concise statement of rationale regarding the factor or factors that caused the new drug to exceed the Medicare Part D Program price. The drug manufacturer shall provide the written notice within three (3) calendar days following the release of the drug in the commercial market. A

drug manufacturer may make the notification pending approval by the United States Food and Drug Administration if commercial availability is expected within three (3) calendar days following the approval.

(4) On or before October 1st of each year, a pharmacy benefit manager or PSAO providing services for a health care plan shall file a report with the board. The report must contain the following information for the previous state fiscal year:

(a) The aggregated rebates, fees, price protection payments and any other payments collected from each drug manufacturer;

(b) The aggregated dollar amount of rebates, price protection payments, fees, and any other payments collected from each drug manufacturer which were passed to health insurers;

(c) The aggregated fees, price concessions, penalties, effective rates, and any other financial incentive collected from pharmacies which were passed to enrollees at the point of sale;

(d) The aggregated dollar amount of rebates, price protection payments, fees, and any other payments collected from drug manufacturers which were retained as revenue by the pharmacy benefit manager or PSAO; and

(e) The aggregated rebates passed on to employers.

(5) Reports submitted by pharmacy benefit managers and PSAOs under this section may not disclose the identity of a specific health benefit plan or enrollee, the identity of a drug

manufacturer, the prices charged for specific drugs or classes of drugs, or the amount of any rebates or fees provided for specific drugs or classes of drugs.

(6) On or before October 1st of each year, each health insurer shall submit a report to the board. The report must contain the following information for the previous two (2) calendar years:

(a) Names of the twenty-five (25) most frequently prescribed drugs across all plans;

(b) Names of the twenty-five (25) prescription drugs dispensed with the highest dollar spent in terms of gross revenue;

(c) Percent of increase in annual net spending for prescription drugs across all plans;

(d) Percent of increase in premiums which is attributable to prescription drugs across all plans;

(e) Percentage of specialty drugs with utilization management requirements across all plans; and

(f) Premium reductions attributable to specialty drug utilization management.

(7) A report submitted by a health insurer may not disclose the identity of a specific health benefit plan or the prices charged for specific prescription drugs or classes of prescription drugs.

(8) The provisions of this section shall apply to the pharmacy benefit manager or PSAO of the Mississippi State and School Employees Health Insurance Plan.

SECTION 4. (1) The board shall develop a website to publish information the board receives under this chapter. The board shall make the website available on the board's website with a dedicated link prominently displayed on the home page, or by a separate, easily identifiable Internet address.

(2) Within sixty (60) days of receipt of reported information under this chapter, the board shall publish the reported information on the website developed under this section. The information the board publishes may not disclose or tend to disclose trade secrets, proprietary, commercial, financial, or confidential information of any pharmacy, pharmacy benefit manager, PSAO, drug wholesaler, or hospital.

(3) The board may adopt rules to implement this chapter. The board shall develop forms that must be used for reporting required under this chapter. The board may contract for services to implement this chapter.

(4) A report received by the board shall not be subject to the provisions of the federal Freedom of Information Act or the Mississippi Public Records Act and shall not be released by the board unless subject to an order from a court of competent jurisdiction. The board shall destroy or delete or cause to be destroyed or deleted all such information thirty (30) days after

the board determines that the information is no longer necessary or useful.

(5) The provisions of this section shall apply to the pharmacy benefit manager and PSAO of the Mississippi State and School Employees Health Insurance Plan.

SECTION 5. (1) Pharmacy benefit managers and PSAOs shall also identify to the board any ownership affiliation of any kind with any pharmacy which, either directly or indirectly, through one or more intermediaries:

(a) Has an investment or ownership interest in a pharmacy benefit manager or PSAO holding a certificate of authority;

(b) Shares common ownership with a pharmacy benefit manager or PSAO holding a certificate of authority in this state; or

(c) Has an investor or a holder of an ownership interest which is a pharmacy benefit manager or PSAO holding a certificate of authority issued in this state.

(2) A pharmacy benefit manager or PSAO shall report any change in information required by this act to the board in writing within sixty (60) days after the change occurs.

(3) The provisions of this section shall apply to the pharmacy benefit manager and PSAO of the Mississippi State and School Employees Health Insurance Plan.

SECTION 6. Every pharmacy benefit manager and PSAO shall disclose to the plan sponsor or employer one hundred percent (100%) of all rebates and other payments that the pharmacy benefit manager or PSAO receives directly or indirectly from pharmaceutical manufacturers and/or rebate aggregators in connection with claims administered on behalf of the plan sponsor or employer and the recipients of such rebates. In addition, a pharmacy benefit manager or PSAO shall report annually to each plan sponsor or employer the aggregate amount of all rebates and other payments and the recipients of such rebates.

The provisions of this section shall apply to the pharmacy benefit manager and PSAO of the Mississippi State and School Employees Health Insurance Plan.

SECTION 7. (1) The board may impose a monetary penalty on a pharmacy benefit manager, a pharmacy benefit manager affiliate or PSAO for noncompliance with the provisions of Sections 1 through 6 of this act, in amounts of not less than One Thousand Dollars ($1,000.00) per violation and not more than Twenty-five Thousand Dollars ($25,000.00) per violation. The board shall prepare a record entered upon its minutes that states the basic facts upon which the monetary penalty was imposed.

(2) For the purposes of conducting investigations, the board may conduct examinations of a pharmacy benefit manager or PSAO and may also issue subpoenas to any individual, pharmacy, pharmacy

benefit manager, PSAO or any other entity having documents or records that it deems relevant to the investigation.

(3) The board may assess a monetary penalty for those reasonable costs that are expended by the board in the investigation and conduct of a proceeding if the board imposes a monetary penalty under subsection (1) of this section. A monetary penalty assessed and levied under this section shall be paid to the board by the licensee, registrant or permit holder upon the expiration of the period allowed for appeal of penalties in the same manner as provided under Section 73-21-101, or may be paid sooner if the licensee, registrant or permit holder elects.

(4) When payment of a monetary penalty assessed and levied by the board against a licensee, registrant or permit holder in accordance with this section is not paid by the licensee, registrant or permit holder when due under this section, the board shall have the power to institute and maintain proceedings in its name for enforcement of payment in the chancery court of the county and judicial district of residence of the licensee, registrant or permit holder, or if the licensee, registrant or permit holder is a nonresident of the State of Mississippi, in the Chancery Court of the First Judicial District of Hinds County, Mississippi. When those proceedings are instituted, the board shall certify the record of its proceedings, together with all documents and evidence, to the chancery court and the matter shall be heard in due course by the court, which shall review the record

and make its determination thereon in the same manner as provided under Section 73-21-101. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

(5) (a) The board may conduct audits to ensure compliance with the provisions of Sections 1 through 6 of this act. In conducting audits, the board is empowered to request production of documents pertaining to compliance with the provisions of Sections 1 through 6 of this act, and documents so requested shall be produced within seven (7) days of the request unless extended by the board or its duly authorized staff.

(b) If, after the conclusion of the audit, the pharmacy benefit manager or PSAO was found to be in compliance with all of the requirements of Sections 1 through 6 of this act, then the board shall pay the costs of the audit. However, if the pharmacy benefit manager or PSAO was not in compliance with all or a part of Sections 1 through 6 of this act, then the pharmacy benefit manager or PSAO being audited shall pay all costs of such audit. The cost of the audit examination shall be deposited into a special fund and shall be used by the board, upon appropriation of the Legislature, to support the operations of the board relating to the auditing of pharmacy benefit managers or PSAOs.

(c) The board is authorized to hire independent consultants to conduct appeal audits of a pharmacy benefit manager or PSAO and expend funds collected under this section to pay the cost of performing audit services.

(6) The provisions of this section shall apply to the pharmacy benefit manager and PSAO of the Mississippi State and School Employees Health Insurance Plan.

SECTION 8. (1) Retaliation is prohibited.

(a) A pharmacy benefit manager or PSAO may not retaliate against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of any right or remedy under this chapter. Retaliation prohibited by this section includes, but is not limited to:

(i) Terminating or refusing to renew a contract with the pharmacist or pharmacy;

(ii) Subjecting the pharmacist or pharmacy to an increased frequency of audits, number of claims audited, or amount of monies for claims audited; or

(iii) Failing to promptly pay the pharmacist or pharmacy any money owed by the pharmacy benefit manager or PSAO to the pharmacist or pharmacy.

(b) For the purposes of this section, a pharmacy benefit manager or PSAO is not considered to have retaliated against a pharmacy if the pharmacy benefit manager or PSAO:

(i) Takes an action in response to a credible allegation of fraud against the pharmacist or pharmacy; and

(ii) Provides reasonable notice to the pharmacist or pharmacy of the allegation of fraud and the basis of the allegation before initiating an action.

(2) A pharmacy benefit manager, pharmacy benefit manager affiliate or PSAO shall not penalize or retaliate against a pharmacist, pharmacy or pharmacy employee for exercising any rights under this chapter, initiating any judicial or regulatory actions or discussing or disclosing information pertaining to an agreement with a pharmacy benefit manager, a pharmacy benefit manager affiliate or PSAO when testifying or otherwise appearing before any governmental agency, legislative member or body or any judicial authority.

(3) The provisions of this section shall apply to the pharmacy benefit manager and PSAO of the Mississippi State and School Employees Health Insurance Plan.

SECTION 9. Section 73-21-155, Mississippi Code of 1972, is brought forward as follows:

73-21-155. (1) Reimbursement under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses Medi-Span, Gold Standard or a nationally recognized reference that has been approved by the board in the pricing calculation shall use the most current reference price or amount in the actual or constructive possession of the pharmacy benefit manager, its agent, or any other party responsible for reimbursement for prescription drugs and other products and supplies on the date of electronic adjudication or on the date of service shown on the nonelectronic claim.

(2) Pharmacy benefit managers, their agents and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.

(3) (a) All benefits payable under a pharmacy benefit management plan shall be paid within seven (7) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within seven (7) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan. A "clean claim" means a claim received by any pharmacy benefit manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefit manager. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that

prevents timely payment from being made on the claim under this subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

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

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

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

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

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

(c) Not later than seven (7) days after the date the pharmacy benefit manager actually receives an electronic claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist

or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the pharmacy benefit manager actually receives a paper claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the pharmacy benefit manager shall be paid within twenty (20) days after receipt.

(4) If the board finds that any pharmacy benefit manager, agent or other party responsible for reimbursement for prescription drugs and other products and supplies has not paid ninety-five percent (95%) of clean claims as defined in subsection (3) of this section received from all pharmacies in a calendar quarter, he shall be subject to administrative penalty of not more than Twenty-five Thousand Dollars ($25,000.00) to be assessed by the State Board of Pharmacy.

(a) Examinations to determine compliance with this subsection may be conducted by the board. The board may contract

with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the pharmacy benefit manager examined.

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

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

(d) Any pharmacy benefit manager and a pharmacy may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (3) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the pharmacy benefit manager to the pharmacy. If the express written

agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (4)(c) of this section shall apply.

(e) The State Board of Pharmacy may adopt rules and regulations necessary to ensure compliance with this subsection.

(5) (a) For purposes of this subsection (5), "network pharmacy" means a licensed pharmacy in this state that has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate. A network pharmacy or pharmacist may decline to provide a brand name drug, multisource generic drug, or service, if the network pharmacy or pharmacist is paid less than that network pharmacy's acquisition cost for the product. If the network pharmacy or pharmacist declines to provide such drug or service, the pharmacy or pharmacist shall provide the customer with adequate information as to where the prescription for the drug or service may be filled.

(b) The State Board of Pharmacy shall adopt rules and regulations necessary to implement and ensure compliance with this subsection, including, but not limited to, rules and regulations that address access to pharmacy services in rural or underserved areas in cases where a network pharmacy or pharmacist declines to provide a drug or service under paragraph (a) of this subsection. The board shall promulgate the rules and regulations required by this paragraph (b) not later than October 1, 2016.

(6) A pharmacy benefit manager shall not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated.

SECTION 10. Section 73-21-156, Mississippi Code of 1972, is brought forward as follows:

73-21-156. (1) As used in this section, the following terms shall be defined as provided in this subsection:

(a) "Maximum allowable cost list" means a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, setting the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product or other prescription drug. The term "maximum allowable cost list" includes without limitation:

(i) Average acquisition cost, including national average drug acquisition cost;

(ii) Average manufacturer price;

(iii) Average wholesale price;

(iv) Brand effective rate or generic effective rate;

(v) Discount indexing;

(vi) Federal upper limits;

(vii) Wholesale acquisition cost; and

(viii) Any other term that a pharmacy benefit manager or a health care insurer may use to establish

reimbursement rates to a pharmacist or pharmacy for pharmacist services.

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

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

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

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

(c) Shall not be obsolete.

(3) A pharmacy benefit manager shall:

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

(b) Update its maximum allowable cost list on a timely basis, but in no event longer than three (3) calendar days; and

(c) Provide a process for each pharmacy subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list.

(4) A pharmacy benefit manager shall:

(a) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge a maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drugs as:

(i) Not meeting the requirements of this section; or

(ii) Being below the pharmacy acquisition cost.

(b) The reasonable administrative appeal procedure shall include the following:

(i) A dedicated telephone number, email address and website for the purpose of submitting administrative appeals;

(ii) The ability to submit an administrative appeal directly to the pharmacy benefit manager regarding the pharmacy benefit management plan or through a pharmacy service administrative organization; and

(iii) A period of less than thirty (30) business days to file an administrative appeal.

(c) The pharmacy benefit manager shall respond to the challenge under paragraph (a) of this subsection (4) within thirty (30) business days after receipt of the challenge.

(d) If a challenge is made under paragraph (a) of this subsection (4), the pharmacy benefit manager shall within thirty (30) business days after receipt of the challenge either:

(i) If the appeal is upheld:

1. Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost;

2. Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;

3. Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and

4. Make the change under item 1 of this subparagraph (i) effective for each similarly situated pharmacy as defined by the payor subject to the maximum allowable cost list; or

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

(iii) If the National Drug Code provided by the pharmacy benefit manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefit manager shall adjust

the maximum allowable cost as listed on the maximum allowable cost list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

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

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

SECTION 11. Section 73-21-183, Mississippi Code of 1972, is brought forward as follows:

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

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

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

(c) The entity conducting the on-site or desk audit shall not interfere with the delivery of pharmacist services to a

patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process;

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

(e) Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not constitute fraud; however, those claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud;

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

(g) A finding of an overpayment or an underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, except that recoupment shall be based on the actual overpayment or underpayment;

(h) A finding of an overpayment shall not include the dispensing fee amount unless a prescription was not dispensed;

(i) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;

(j) The period covered by an audit may not exceed two (2) years from the date the claim was submitted to or adjudicated by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that represents those companies, groups, or department;

(k) An audit may not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy;

(l) Any prescription that complies with state law and rule requirements may be used to validate claims in connection with prescriptions, refills or changes in prescriptions;

(m) An exit interview that provides a pharmacy with an opportunity to respond to questions and comment on and clarify findings must be conducted at the end of an audit. The time of the interview must be agreed to by the pharmacy;

(n) Unless superseded by state or federal law, auditors shall only have access to previous audit reports on a particular pharmacy conducted by the auditing entity for the same pharmacy benefits manager, health plan or insurer. An auditing vendor

contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan;

(o) The parameters of an audit must comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:

(i) The day supply for eyedrops must be calculated so that the consumer pays only one (1) thirty-day copayment if the bottle of eyedrops is intended by the manufacturer to be a thirty-day supply;

(ii) The day supply for insulin must be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment;

(iii) The day supply for a topical product must be determined by the judgment of the pharmacist based upon the treated area;

(p) (i) Where an audit is for a specifically identified problem that has been disclosed to the pharmacy, the audit shall be limited to claims that are identified by prescription number;

(ii) For an audit other than described in subparagraph (i) of this paragraph (p), an audit shall be limited

to one hundred (100) individual prescriptions that have been randomly selected;

(iii) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on site;

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

(r) A recoupment shall not be based on:

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

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

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

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

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

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

(b) A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request;

(c) A final audit report shall be delivered to the pharmacy within one hundred eighty (180) days after receipt of the preliminary audit report or final appeal, as provided for in Section 73-21-185, whichever is later;

(d) The audit report must be signed by the auditor;

(e) Recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final internal disposition of the audit, including the appeals process as set forth in Section 73-21-185. If the identified discrepancy for an individual audit exceeds Twenty-five Thousand Dollars ($25,000.00), future payments in excess of that amount to the pharmacy may be withheld pending finalization of the audit;

(f) Interest shall not accrue during the audit period; and

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

SECTION 12. This act shall take effect and be in force from and after July 1, 2025, and Sections 1 through 8 shall stand repealed on June 30, 2028.