ARTICLE 61
Pharmacy Benefits Manager Regulation

Section

59A-61-1. Short title.

Sections 1 through 6 [59A-61-1 through 59A-61-6 NMSA 1978] of this act may be cited as the "Pharmacy Benefits Manager Regulation Act".

History: Laws 2014, ch. 14, § 1.

59A-61-2. Definitions.

As used in the Pharmacy Benefits Manager Regulation Act:

A. "covered entity" means a nonprofit hospital or medical service corporation, health insurer, health benefit plan or health maintenance organization; a health program administered by the state as a provider of health coverage; any type of group health care coverage, including any form of self-insurance offered, issued or renewed pursuant to the Health Care Purchasing Act [Chapter 13, Article 7 NMSA 1978]; or an employer, labor union or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state. "Covered entity" does not include a self-funded plan that is exempt from state regulation pursuant to the federal Employee Retirement Income Security Act of 1974; a plan issued for coverage for federal employees; or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts;

B. "covered individual" means a member, participant, enrollee, contract holder, policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity and includes a dependent or other person provided health coverage through a policy, contract or plan for a covered individual;

C. "medicare advantage plan" or "MA-PD" means a prescription drug program authorized pursuant to Part C of Title 18 of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that provides qualified prescription drug coverage;

D. "pharmacist" means an individual licensed as a pharmacist by the board of pharmacy;

E. "pharmacy" means a licensed place of business where drugs are compounded or dispensed and pharmacist services are provided;

F. "pharmacy benefits management" means the service provided to a health benefit plan or health insurer, directly or through another person, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including:

(1) mail service pharmacies; and

(2) claims processing, retail network management or payment of claims to pharmacies for dispensing dangerous drugs, as those drugs are defined in the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978];

G. "pharmacy benefits manager" means a person or a wholly or partially owned or controlled subsidiary of a person that provides claims administration, benefit design and management, pharmacy network management, negotiation and administration of product discounts, rebates and other benefits accruing to the pharmacy benefits manager or other prescription drug or device services to third parties, but "pharmacy benefits manager" does not include licensed health care facilities, pharmacies, licensed health care professionals, health insurers, unions, health maintenance organizations, medicare advantage plans or prescription drug plans when providing formulary services to their own patients, employees, members or beneficiaries;

H. "prescription drug plan" or "PDP" means prescription drug coverage that is offered pursuant to a policy, contract or plan that has been approved as specified in 42 CFR Part 423 and that is offered by a prescription drug plan sponsor that has a contract with the federal centers for medicare and medicaid services of the United States department of health and human services; and

I. "superintendent" means the superintendent of insurance.

History: Laws 2014, ch. 14, § 2.

59A-61-3. License.

A. A person shall not operate as a pharmacy benefits manager unless licensed by the superintendent in accordance with the Pharmacy Benefits Manager Regulation Act and applicable federal and state laws.

B. An application for licensure as a pharmacy benefits manager shall require only the following information:

(1) the identity of the pharmacy benefits manager;

(2) the name and business address of the contact person for the pharmacy benefits manager; and

(3) where applicable, the federal employer identification number for the pharmacy benefits manager.

C. The superintendent shall enforce the provisions of the Pharmacy Benefits Manager Regulation Act and may suspend or revoke a license issued to a pharmacy benefits manager or deny an application for a license or renewal of a license if:

(1) the pharmacy benefits manager is operating materially in contravention of its application;

(2) the pharmacy benefits manager has failed to continuously meet or substantially comply with the requirements for issuance of a license;

(3) the pharmacy benefits manager has failed to substantially comply with applicable state or federal laws or rules; or

(4) the pharmacy benefits manager has transacted insurance in the state without authorization or has transacted insurance for a product that is not issued by an authorized insurer.

D. If the license of a pharmacy benefits manager is revoked, the manager shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and

conduct no further business except as may be essential to the orderly conclusion of its affairs. The superintendent may permit further operation of the pharmacy benefits manager if the superintendent finds it to be in the best interest of patients to obtain pharmacist services.

E. A person whose pharmacy benefits manager license has been denied, suspended or revoked may seek review of the denial, suspension or revocation pursuant to the provisions of Chapter 59A, Article 4 NMSA 1978.

History: Laws 2014, ch. 14, § 3.

59A-61-4. Maximum allowable cost pricing requirements.

A. A pharmacy benefits manager using maximum allowable cost pricing shall:

(1) to place a drug on a maximum allowable cost list, ensure that the drug:

(a) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book";

(b) has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(c) is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(2) provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(3) review and update maximum allowable cost price information at least once every seven business days to reflect any modification of maximum allowable cost pricing;

(4) establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(5) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug and respond to a challenge not later than the fifteenth day after the date the challenge is made. If the challenge is successful, a pharmacy benefits manager using maximum allowable cost pricing shall make an adjustment in the drug price effective one day after the challenge is resolved, and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefits manager, as appropriate. If the challenge is denied, the pharmacy benefits manager using maximum allowable cost pricing shall provide the reason for the denial; and

(6) provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider.

B. A maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefits manager is confidential.

C. As used in this section, "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug.

History: Laws 2014, ch. 14, § 4.

59A-61-5. Pharmacy benefits manager contracts.

A. A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract.

B. Each pharmacy benefits manager shall provide to the pharmacies, at least thirty days prior to its execution, a contract written in plain English.

C. A contract between a pharmacy benefits manager and a pharmacy shall provide specific time limits for the pharmacy benefits manager to pay the pharmacy for services rendered.

History: Laws 2014, ch. 14, § 5.

59A-61-6. Audit; pharmacy benefits manager.

A pharmacy benefits manager, whether licensed pursuant to the Pharmacy Benefits Manager Regulation Act or exempt from licensure pursuant to that act, shall be subject to Section 61-11-18.2 NMSA 1978.

History: Laws 2014, ch. 14, § 6.

61-11-18.2. Audit of pharmacy records. (Repealed effective July 1, 2016.)

A. As used in this section, "entity" means a managed care company, insurance company, third-party payor or the representative of the managed care company, insurance company or third-party payor.

B. An audit of the records of a pharmacy by an entity shall be conducted in accordance with the following criteria:

(1) the entity conducting the initial on-site audit shall give the pharmacy notice at least two weeks prior to conducting the initial on-site audit for each audit cycle;

(2) an audit that involves clinical or professional judgment shall be conducted by or in consultation with a pharmacist;

(3) a clerical or record-keeping error, regarding a required document or record, shall not necessarily constitute fraud but such a claim:

(a) may be subject to recoupment; and

(b) shall not be subject to criminal penalties without proof of intent to commit fraud;

(4) 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 dangerous drug or controlled substance;

(5) a finding of an overpayment or underpayment shall not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs and recoupment of claims shall be based on the actual overpayment or underpayment unless the entity demonstrates a statistically justifiable method of projection or the projection for overpayment or underpayment is part of a settlement as agreed to by the pharmacy;

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

(7) a pharmacy shall be allowed at least twenty-one business days, with reasonable extensions allowed, following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit;

(8) the period covered by an audit shall not exceed two years, unless otherwise provided by contractual agreement, from the date the claim was submitted to or adjudicated by an entity or unless it conflicts with state or federal law;

(9) an audit shall not be initiated or scheduled during the first five calendar days of a month due to the high volume of prescriptions filled during that time unless otherwise consented to by the pharmacy;

(10) the preliminary audit report shall be delivered to the pharmacy within one hundred twenty days, with reasonable extensions allowed, after conclusion of the audit, and the final report shall be delivered to the pharmacy within six months after receipt of the preliminary audit report or final appeal, as provided for in Subsection C of this section, whichever is later;

(11) the audit criteria set forth in this subsection shall apply only to audits of claims submitted for payment after July 1, 2007; and

(12) notwithstanding any other provision in this subsection, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits.

C. Recoupment of any disputed funds shall occur after final internal disposition of the audit, including the appeals process set forth in Subsection D of this section. Should the identified discrepancy for an individual audit exceed twenty-five thousand dollars ($25,000), future payments to the pharmacy may be withheld pending finalization of the audit.

D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity. If, following the appeal, the entity finds that an unfavorable audit report or any portion of the audit is unsubstantiated, the entity shall dismiss the audit report or the unsubstantiated portion of the report of the audit without the necessity of any further proceedings.

E. This section does not apply to any investigative audit that involves probable or potential fraud, willful misrepresentation.

History: Laws 2007, ch. 15, § 1.