BILL ANALYSIS

C.S.H.B. 3366
By: Sheffield
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Recent changes in the provision of prescription drug benefits through the Medicaid managed care program have resulted in a drastic reduction in reimbursement for some pharmacies. It has been reported that Medicaid pharmacy benefit managers routinely reimburse pharmacies at rates below the actual cost for many drugs and that, taking into account the cost of purchasing the pharmaceuticals, reimbursements to pharmacies have decreased by over 50 percent for some plans. C.S.H.B. 3366 seeks to ensure that reimbursement rates for prescription drugs accurately reflect the actual cost of the drugs.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3366 amends the Government Code, including provisions amended by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015, to remove the requirement that the provision of a Medicaid managed care contract between a managed care organization and the Health and Human Services Commission (HHSC) regarding the outpatient pharmacy benefit plan of a managed care organization or pharmacy benefit manager include certain specified requirements relating to the criteria for a drug to be placed on the maximum allowable cost list, the formulation of the maximum allowable cost price for a drug, the elimination of drugs from the maximum allowable cost list and the modification of prices of drugs on the list, and the notification of HHSC after the implementation of a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail. The bill instead requires that contract provision to require the managed care organization or pharmacy benefit manager to comply with the bill's provisions relating to reimbursement methodology for prescription drugs as a condition of contract retention and renewal. The bill updates references to the maximum allowable cost list to refer instead to the drug reimbursement price list and updates references to the maximum allowable cost price to refer instead to the actual acquisition cost (AAC) price. The bill repeals a provision providing for the confidentiality of a maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefit manager.

C.S.H.B. 3366 requires a managed care organization that contracts with HHSC under the Medicaid managed care program or a pharmacy benefit manager administering a pharmacy benefit program on behalf of the managed care organization to reimburse a pharmacy or pharmacist that dispenses a prescribed prescription drug to a recipient for not less than the lesser

of the average of Texas pharmacies' actual acquisition cost (AAC) for the drug, plus a dispensing fee that is not less than the dispensing fee adopted by the executive commissioner of HHSC or the amount claimed by the pharmacy or pharmacist, including the gross amount due or the usual and customary charge to the public for the drug. The bill requires the methodology adopted by the executive commissioner to determine Texas pharmacies' actual acquisition cost (AAC) to be consistent with the actual prices Texas pharmacies pay to acquire prescription drugs marketed or sold by a specific manufacturer and authorizes the methodology to be based on the National Average Drug Acquisition Cost published by the Centers for Medicare and Medicaid Services or another publication approved by the executive commissioner. The bill requires the dispensing fee adopted by the executive commissioner to be equal to at least $6 and must be based on the savings achieved by the state by the use of actual acquisition cost (AAC) pricing. The bill requires the executive commissioner to develop a process for the periodic study of Texas pharmacies' actual acquisition cost (AAC) for prescription drugs and to publish the results of each study on the HHSC website.

C.S.H.B. 3366 amends the Health and Safety Code to require a managed care organization providing pharmacy benefits under the child health plan program or a pharmacy benefit manager administering a pharmacy benefit program on behalf of the managed care organization to comply with the bill's provisions related to reimbursement methodology for prescription drugs.

C.S.H.B. 3366 amends the Human Resources Code, as amended by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015, to change the pricing standard required to be used by HHSC in determining reimbursement amounts under the Medicaid vendor drug program from a nationally recognized, unbiased pricing standard for prescription drugs to the reimbursement methodology provided under the bill's provisions.

C.S.H.B. 3366 repeals Section 533.005 (a-2), Government Code.

EFFECTIVE DATE

March 1, 2016.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 3366 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill and does not indicate differences relating to changes made by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015, which became effective April 2, 2015.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 533.005(a), Government Code, is amended to read as follows:	SECTION 1. Section 533.005(a), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:
(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:	(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:
(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization	(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization

review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on

review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on

the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health

the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health

care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal;

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider; and

(D) the managed care organization to allow a provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care

care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal;

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider; and

(D) the managed care organization to allow a provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care

organization:
(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to:
(i) preventive care;
(ii) primary care;
(iii) specialty care;
(iv) after-hours urgent care;
(v) chronic care;
(vi) long-term services and supports;
(vii) nursing services; and
(viii) therapy services, including services provided in a clinical setting or in a home or community-based setting; and
(B) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Paragraph (A) and specific data with respect to Paragraphs (A)(iii), (vi), (vii), and (viii) on the average length of time between:
(i) the date a provider makes a referral for the care or service and the date the organization approves or denies the referral; and
(ii) the date the organization approves a referral for the care or service and the date the care or service is initiated;
(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:
(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;
(B) the organization's provider network includes:
(i) a sufficient number of primary care providers;
(ii) a sufficient variety of provider types;
(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and
(iv) providers located throughout the region where the organization will provide health care services; and
(C) health care services will be accessible

organization:
(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to:
(i) preventive care;
(ii) primary care;
(iii) specialty care;
(iv) after-hours urgent care;
(v) chronic care;
(vi) long-term services and supports;
(vii) nursing services; and
(viii) therapy services, including services provided in a clinical setting or in a home or community-based setting; and
(B) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Paragraph (A) and specific data with respect to Paragraphs (A)(iii), (vi), (vii), and (viii) on the average length of time between:
(i) the date a provider makes a referral for the care or service and the date the organization approves or denies the referral; and
(ii) the date the organization approves a referral for the care or service and the date the care or service is initiated;
(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:
(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;
(B) the organization's provider network includes:
(i) a sufficient number of primary care providers;
(ii) a sufficient variety of provider types;
(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and
(iv) providers located throughout the region where the organization will provide health care services; and
(C) health care services will be accessible

to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under the Medicaid program;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care

to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care

organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code; and

(K) under which the managed care organization or pharmacy benefit manager, as applicable, must comply with Section 533.00512 as a condition of contract retention and renewal[~~:~~

[~~(i) to place a drug on a maximum allowable cost list, must ensure that:~~

[~~(a) the drug 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, has an "NR" or "NA" rating or a similar rating by a nationally~~

organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code; and

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) must comply with Section 533.00512 as a condition of contract retention and renewal [~~to place a drug on a maximum allowable cost list, must ensure that:~~

[~~(a) the drug 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, has an "NR" or "NA" rating or a similar rating by a nationally~~

recognized reference; and

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

[(ii) must 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;

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

[(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent 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;

[(v) must 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;

[(vi) must:

[(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

[(b) respond to a challenge not later than the 15th day after the date the challenge is made;

[(c) if the challenge is successful, make an adjustment in the drug price effective on the date 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 benefit manager, as appropriate;

[(d) if the challenge is denied, provide the reason for the denial; and

[(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list

recognized reference; and

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

(ii) must 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 actual acquisition [maximum allowable] cost (AAC) pricing [for the maximum allowable cost list specific to that provider];

(iii) must review and update drug reimbursement [maximum allowable cost] price information at least once every seven days to reflect any modification of the actual acquisition [maximum allowable] cost (AAC) pricing or the factors used to determine that pricing;

(iv) [must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent 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;

[(v) must 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;

[(vi)] must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed actual acquisition [maximum allowable] cost (AAC) price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date 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 benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each [maximum allowable cost

~~drug for which a challenge was denied during the period;~~

[~~(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail; and~~

[~~(viii) must provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider~~];

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan; and

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reduction; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission.

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00512 to read as follows:

Sec. 533.00512. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. (a) A managed care organization that contracts with the commission under this chapter or a pharmacy benefit manager administering a pharmacy benefit program on behalf of the managed care organization shall reimburse a pharmacy or pharmacist that dispenses a prescribed prescription drug to a recipient for:

(1) subject to Subsection (b), the drug ingredient cost using the National Average Drug Acquisition Cost published by the Centers for Medicare and Medicaid Services; and

~~list~~] drug for which a challenge was denied during the period; and

(v) [~~(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail; and~~

[~~(viii)~~] must provide a process for each of its network pharmacy providers to readily access the drug reimbursement price [~~maximum allowable cost~~] list specific to that provider;

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan; and

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reduction; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission.

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00512 to read as follows:

Sec. 533.00512. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. (a) A managed care organization that contracts with the commission under this chapter or a pharmacy benefit manager administering a pharmacy benefit program on behalf of the managed care organization shall reimburse a pharmacy or pharmacist that dispenses a prescribed prescription drug to a recipient for not less than the lesser of:

No equivalent provision. *(But see Section 533.00512(b), Government Code, below.)*

(2) except as provided by Subsection (e), the cost of dispensing the drug by paying the pharmacy or pharmacist, as applicable, a dispensing fee equal to the greater of $7.93 plus an amount equal to 1.96 percent of the amount paid under Subdivision (1) or Subsection (b), as applicable.	No equivalent provision. *(But see Section 533.00512(c), Government Code, below.)*
No equivalent provision.	(1) the average of Texas pharmacies' actual acquisition cost (AAC) for the drug, plus a dispensing fee that is not less than the dispensing fee adopted by the executive commissioner; or (2) the amount claimed by the pharmacy or pharmacist, including the gross amount due or the usual and customary charge to the public for the drug.
No equivalent provision. *(But see Section 533.00512(a)(1), Government Code, above.)*	(b) The methodology adopted by the executive commissioner to determine Texas pharmacies' actual acquisition cost (AAC) for purposes of Subsection (a) must be consistent with the actual prices Texas pharmacies pay to acquire prescription drugs marketed or sold by a specific manufacturer and may be based on the National Average Drug Acquisition Cost published by the Centers for Medicare and Medicaid Services or another publication approved by the executive commissioner.
No equivalent provision. *(But see Section 533.00512(a)(2), Government Code, above.)*	(c) The dispensing fee adopted by the executive commissioner for purposes of Subsection (a) must be equal to at least $6 and must be based on the savings achieved by the state by the use of actual acquisition cost (AAC) pricing.
(b) If a National Average Drug Acquisition Cost is not available to determine the ingredient cost of a prescription drug for the purpose of Subsection (a)(1), the managed care organization or pharmacy benefit manager shall reimburse the pharmacy or pharmacist for the drug ingredient cost using: (1) the wholesale acquisition cost, less an amount equal to two percent of that cost; or (2) an amount equal to the amount paid for the drug under the traditional fee-for-service arrangement.	No equivalent provision.

(c) A managed care organization that contracts with the commission under this chapter or a pharmacy benefit manager administering a pharmacy benefit program on behalf of the managed care organization shall review and update cost information at least once every seven days to reflect any modification of the National Average Drug Acquisition Cost or wholesale acquisition cost for a prescription drug.	No equivalent provision.
(d) Not later than December 1, 2016, the commission shall complete a study of the average cost of dispensing prescription drugs for pharmacies and pharmacists participating in the Medicaid managed care and child health plan programs. The commission may contract with a third party to conduct the study required by this subsection. This subsection expires September 1, 2017.	(d) The executive commissioner shall develop a process for the periodic study of Texas pharmacies' actual acquisition cost (AAC) for prescription drugs and publish the results of each study on the commission's Internet website.
(e) If the executive commissioner finds, as a result of the study conducted under Subsection (d), that the average cost of dispensing prescription drugs under the Medicaid managed care and child health plan programs is greater than $10.12, the executive commissioner by rule may establish a dispensing fee greater than the fee required by Subsection (a)(2).	No equivalent provision.
SECTION 3. Subchapter D, Chapter 62, Health and Safety Code, is amended.	SECTION 3. Same as introduced version.
No equivalent provision.	SECTION 4. Section 32.0462(a), Human Resources Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows: (a) Notwithstanding any other provision of state law, the commission shall: (1) use the reimbursement methodology under Section 533.00512, Government Code, to determine [~~consider a nationally recognized, unbiased pricing standard for prescription drugs in determining~~] reimbursement amounts under the vendor drug program; and (2) update reimbursement amounts under the vendor drug program at least weekly.

SECTION 4. Section 533.005(a-2), Government Code, is repealed.	SECTION 5. Same as introduced version.
SECTION 5. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.	SECTION 6. Same as introduced version.
SECTION 6. This Act takes effect September 1, 2015.	SECTION 7. This Act takes effect March 1, 2016.