SENATE AMENDMENTS

2nd Printing

By: Sheffield, Bonnen of Galveston, Price, Hefner, Raymond, et al. H.B. No. 3388

A BILL TO BE ENTITLED

AN ACT

relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.

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

SECTION 1. Section 533.005(a), Government Code, 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:

(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 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 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 complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) 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 Section 533.0061(a) and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization 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, subject to the provider access standards established under Section 533.0061:

(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 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:

(i) <u>must comply with Section 533.00514 as a condition of contract retention and renewal</u> [~~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 drug reimbursement [~~maximum allowable cost~~] price information at least once every seven days to reflect any modification of [~~maximum allowable cost~~] pricing under the vendor drug program;

(iii) [~~(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 the reimbursement [~~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~~] drug for which a challenge was denied during the period; and

(iv) [~~(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;

(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 reductions [~~reduction~~]; or

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

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00514 to read as follows:

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. (a) In accordance with rules adopted by the executive commissioner, 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, including a Texas retail pharmacy or a Texas specialty pharmacy, that:

(1) dispenses a prescribed prescription drug, other than a drug obtained under Section 340B, Public Health Service Act (42 U.S.C. Section 256b), to a recipient for not less than the lesser of:

(A) the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee for the drug under the vendor drug program;

or

(B) 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; or

(2) dispenses a prescribed prescription drug obtained at a discounted price under Section 340B, Public Health Service Act (42 U.S.C. Section 256b) to a recipient for not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee for the drug under the vendor drug program.

(b) The methodology adopted by rule by the executive commissioner to determine Texas pharmacies' actual acquisition cost (AAC) for purposes of the vendor drug program must be consistent with the actual prices Texas pharmacies pay to acquire prescription drugs marketed or sold by a specific manufacturer and must 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.

(c) The executive commissioner shall develop a process for the periodic study of Texas retail pharmacies' actual acquisition cost (AAC) for prescription drugs, Texas specialty pharmacies' actual acquisition cost (AAC) for prescription drugs, retail professional dispensing costs, and specialty pharmacy professional dispensing costs and publish the results of each study on the commission's Internet website.

(d) The dispensing fees adopted by the executive commissioner for purposes of:

(1) Subsection (a)(1) must be based on, as appropriate:

(A) Texas retail pharmacies' professional dispensing costs for retail prescription drugs; or

(B) Texas specialty pharmacies' professional dispensing costs for specialty prescription drugs; or

(2) Subsection (a)(2) must be based on Texas pharmacies' professional dispensing costs for those drugs.

(e) Not less frequently than once every two years, the commission shall conduct a study of Texas pharmacies' dispensing costs for retail prescription drugs, specialty prescription drugs, and drugs obtained under Section 340B, Public Health Service Act (42 U.S.C. Section 256b). Based on the results of the study, the executive commissioner shall adjust the minimum amount of the retail professional dispensing fee and specialty pharmacy professional dispensing fee under Subsection (a)(1) and the dispensing fee for drugs obtained under Section 340B, Public Health Service Act (42 U.S.C. Section 256b).

SECTION 3. Subchapter D, Chapter 62, Health and Safety Code, is amended by adding Section 62.160 to read as follows:

Sec. 62.160. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. 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 shall comply with Section 533.00514, Government Code.

SECTION 4. Section 533.005(a-2), Government Code, is repealed.

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. This Act takes effect March 1, 2020.

ADOPTED

MAY 2 2 2019

Secretary of the Senate

By: Sheffield / Kolkhorst __.B. No. ______

Substitute the following for __.B. No. ______:

By: [illegible] C.S.H.B. No. 3388

A BILL TO BE ENTITLED

AN ACT

relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.

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

SECTION 1. Section 533.005(a), Government Code, 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:

(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 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 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 complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) 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 Section 533.0061(a) and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization 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, subject to the provider access standards established under Section 533.0061:

(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 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:

(i) must comply with Section 533.00514 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 drug reimbursement [~~maximum allowable cost~~] price information at least once every seven days to reflect any modification of [~~maximum allowable cost~~] pricing under the vendor drug program;

(iii) [~~(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 the reimbursement [~~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~~] drug for which a challenge was denied during the period; <u>and</u>

<u>(iv)</u> [~~(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 <u>drug reimbursement price</u> [~~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;

(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 reductions [~~reduction~~]; or

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

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00514 to read as follows:

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. (a) In accordance with rules adopted by the executive commissioner, 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, including a Texas retail pharmacy or a Texas specialty pharmacy, that:

(1) dispenses a prescribed prescription drug, other than a drug obtained under Section 340B, Public Health Service Act (42 U.S.C. Section 256b), to a recipient for not less than the lesser of:

(A) the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee for the drug under the vendor drug program;

or

(B) 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; or

(2) dispenses a prescribed prescription drug obtained at a discounted price under Section 340B, Public Health Service Act (42 U.S.C. Section 256b) to a recipient for not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee for the drug under the vendor drug program.

(b) The methodology adopted by rule by the executive commissioner to determine Texas pharmacies' actual acquisition cost (AAC) for purposes of the vendor drug program must be consistent with the actual prices Texas pharmacies pay to acquire prescription drugs marketed or sold by a specific manufacturer and must 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.

(c) The executive commissioner shall develop a process for the periodic study of Texas retail pharmacies' actual acquisition cost (AAC) for prescription drugs, Texas specialty pharmacies' actual acquisition cost (AAC) for prescription drugs, retail professional dispensing costs, and specialty pharmacy professional dispensing costs and publish the results of each study on the commission's Internet website.

(d) The dispensing fees adopted by the executive commissioner for purposes of:

(1) Subsection (a)(1) must be based on, as appropriate:

(A) Texas retail pharmacies' professional dispensing costs for retail prescription drugs; or

(B) Texas specialty pharmacies' professional dispensing costs for specialty prescription drugs; or

(2) Subsection (a)(2) must be based on Texas pharmacies' professional dispensing costs for those drugs.

(e) Not less frequently than once every two years, the commission shall conduct a study of Texas pharmacies' dispensing costs for retail prescription drugs, specialty prescription drugs, and drugs obtained under Section 340B, Public Health Service Act (42 U.S.C. Section 256b). Based on the results of the study, the executive commissioner shall adjust the minimum amount of the retail professional dispensing fee and specialty pharmacy professional dispensing fee under Subsection (a)(1) and the dispensing fee for drugs obtained under Section 340B, Public Health Service Act (42 U.S.C. Section 256b).

SECTION 3. Subchapter D, Chapter 62, Health and Safety Code, is amended by adding Section 62.160 to read as follows:

Sec. 62.160. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. 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 shall comply with Section 533.00514, Government Code.

SECTION 4. Section 533.005(a-2), Government Code, is repealed.

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. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the Health and Human Services Commission may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

SECTION 7. This Act takes effect March 1, 2020.

ADOPTED

MAY 22 2019

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY: Lois W. Kolkhorst

Amend C.S.H.B. 3388 (senate committee printing) as follows:

(1) In SECTION 1 of the bill, in amended Section 533.005(a)(23)(K)(i), Government Code (page 5, line 9), between "renewal" and "[", insert ", if applicable".

(2) In SECTION 2 of the bill, in added Section 533.00514, Government Code (page 7, between lines 8 and 9), insert the following:

(f) Notwithstanding any other provision of this section, the executive commissioner by rule may establish a minimum dispensing fee that is less than the fee required under Subsections (a) and (d) and may implement the minimum fee amount only after publishing the adopted rule.

(g) The commission shall encourage a managed care organization that contracts with the commission to provide health care services to recipients under this chapter to include in the organization's network all pharmacies that will promote value under an alternative payment model or other quality-based payment system developed by the organization in accordance with rules adopted by the executive commissioner. The payment system may include shared savings and incentive medication adherence, disease management, and comprehensive medication management.

(h) This section expires September 1, 2023.

(3) In SECTION 3 of the bill, in added Section 62.160, Health and Safety Code (page 7, line 16), after the underlined period, insert the following:

This section expires September 1, 2023.

(4) Strike SECTION 5 of the bill (page 7, lines 19-24) and substitute the following appropriately numbered SECTION:

SECTION ____. (a) If before implementing a 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 all provisions of this Act until the waiver or authorization is granted.

(b) Notwithstanding any other provision of this Act:

(1) if Health and Human Services Commission delays implementation of the provisions of this Act under Subsection (a) of this section, the changes in law made by those provisions apply beginning on the 180th day after the date the commission receives the authorization described that subsection; and

(2) until the changes in law made by this Act apply, the law as it existed immediately before the effective date of this Act applies, and the former law is continued in effect for that purpose.

(5) Add the following appropriately numbered SECTION to the bill and renumber subsequent SECTIONS of the bill accordingly:

SECTION ____. (a) Not later than December 31, 2022, the Health and Human Services Commission shall submit a report to the legislature on the impact of this Act on and the changes made to prescription drug pricing and reimbursement under the Medicaid managed care program under Chapter 533, Government Code, and the child health plan program under Chapter 62, Health and Safety Code. The report must include an analysis and comparison of drug price deflation, professional fees, and trends in other public benefits programs, including Medicare under Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.).

(b) This section expires September 1, 2023.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 23, 2019

TO: Honorable Dennis Bonnen, Speaker of the House, House of Representatives

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB3388** by Sheffield (Relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, As Passed 2nd House: a negative impact of ($8,172,748) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill. The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill. The agency is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the agency may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	$0
2021	($8,172,748)
2022	($12,824,106)
2023	($13,781,188)
2024	($14,814,915)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Tobacco Receipts Match For Chip* 8025	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1
2020	$0	$0	$0	$0
2021	($8,293,500)	($259,883)	($13,457,091)	$285,476
2022	($12,992,796)	($448,192)	($21,809,439)	$462,661
2023	($13,962,467)	($481,642)	($23,437,110)	$497,191
2024	($15,009,792)	($517,770)	($25,195,129)	$534,485

Fiscal Year	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	$0
2021	$95,159
2022	$154,221
2023	$165,730
2024	$178,162

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC) to mandate that MCOs providing services under Medicaid or the Children's Health Insurance Program (CHIP) reimburse retail and specialty pharmacies a minimum of the lesser of the reimbursement amount for the drug in the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program, 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 would also require MCOs to reimburse pharmacies that dispense a prescription drug at a discounted price under Section 340B of the Public Health Service Act not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program. The Executive Commissioner of HHSC may establish a minimum dispensing fee in certain circumstances after publishing the adopted rule. The cost estimates discussed below could be significantly lower if HHSC establishes a lower minimum dispensing fee.

The bill would require HHSC to conduct a study of Texas pharmacies' actual acquisition costs and dispensing cost at least every two years. The bill would take effect March 1, 2020.

Methodology

This analysis assumes implementation on January 1, 2021. Based on estimates provided by HHSC, this analysis assumes caseloads of 2,416,365 in fiscal year 2021, 3,993,270 in fiscal year 2022, 4,067,666 in fiscal year 2023, and 4,144,903 in fiscal year 2024, and pharmacy reimbursement that is 0.8 percent higher than under the current reimbursement model.

The net increased client services cost, including amounts for the Health Insurance Providers Fee, is estimated to be $22.8 million in All Funds, including $8.6 million in General Revenue, in fiscal year 2021, increasing to $36.9 million in All Funds, including $13.4 million in General Revenue, in fiscal year 2022 and continuing to increase to $42.6 million in fiscal year 2024, including $15.5 million in General Revenue.

This analysis assumes that any additional administrative costs to the MCOs or MCO pharmacy benefit managers for changes to the reimbursement methodology or to implement the required dispensing fees could be absorbed with existing resources.

The net increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures; resulting in assumed increased collections of $0.4 million in fiscal year 2021, $0.6 million in fiscal year 2022, and $0.7 million in fiscal year 2023 and fiscal year 2024. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission
LBB Staff: WP, AKi, EP, MDI

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 16, 2019

TO: Honorable Lois W. Kolkhorst, Chair, Senate Committee on Health & Human Services

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB3388** by Sheffield (Relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.), **Committee Report 2nd House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, Committee Report 2nd House, Substituted: a negative impact of ($8,172,748) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill. The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill. The agency is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the agency may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	$0
2021	($8,172,748)
2022	($12,824,106)
2023	($13,781,188)
2024	($14,814,915)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Tobacco Receipts Match For Chip* 8025	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1
2020	$0	$0	$0	$0
2021	($8,293,500)	($259,883)	($13,457,091)	$285,476
2022	($12,992,796)	($448,192)	($21,809,439)	$462,661
2023	($13,962,467)	($481,642)	($23,437,110)	$497,191
2024	($15,009,792)	($517,770)	($25,195,129)	$534,485

Fiscal Year	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	$0
2021	$95,159
2022	$154,221
2023	$165,730
2024	$178,162

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC) to mandate that MCOs providing services under Medicaid or the Children's Health Insurance Program (CHIP) reimburse retail and specialty pharmacies a minimum of the lesser of the reimbursement amount for the drug in the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program, 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 would also require MCOs to reimburse pharmacies that dispense a prescription drug at a discounted price under Section 340B of the Public Health Service Act not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program. The bill would require HHSC to conduct a study of Texas pharmacies' actual acquisition costs and dispensing cost at least every two years. The bill would take effect March 1, 2020.

Methodology

This analysis assumes implementation on January 1, 2021. Based on estimates provided by HHSC, this analysis assumes caseloads of 2,416,365 in fiscal year 2021, 3,993,270 in fiscal year 2022, 4,067,666 in fiscal year 2023, and 4,144,903 in fiscal year 2024, and pharmacy reimbursement that is 0.8 percent higher than under the current reimbursement model.

The net increased client services cost, including amounts for the Health Insurance Providers Fee, is estimated to be $22.8 million in All Funds, including $8.6 million in General Revenue, in fiscal year 2021, increasing to $36.9 million in All Funds, including $13.4 million in General Revenue, in fiscal year 2022 and continuing to increase to $42.6 million in fiscal year 2024, including $15.5 million in General Revenue.

This analysis assumes that any additional administrative costs to the MCOs or MCO pharmacy benefit managers for changes to the reimbursement methodology or to implement the required dispensing fees could be absorbed with existing resources.

The net increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures; resulting in assumed increased collections of $0.4 million in fiscal year 2021, $0.6 million in fiscal year 2022, and $0.7 million in fiscal year 2023 and fiscal year 2024. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission

LBB Staff: WP, AKi, EP, MDI

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 10, 2019

TO: Honorable Lois W. Kolkhorst, Chair, Senate Committee on Health & Human Services

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB3388** by Sheffield (Relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.), **As Engrossed**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, As Engrossed: a negative impact of ($8,172,748) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	$0
2021	($8,172,748)
2022	($12,824,106)
2023	($13,781,188)
2024	($14,814,915)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Tobacco Receipts Match For Chip* 8025	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1
2020	$0	$0	$0	$0
2021	($8,293,500)	($259,883)	($13,457,091)	$285,476
2022	($12,992,796)	($448,192)	($21,809,439)	$462,661
2023	($13,962,467)	($481,642)	($23,437,110)	$497,191
2024	($15,009,792)	($517,770)	($25,195,129)	$534,485

Fiscal Year	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	$0
2021	$95,159
2022	$154,221
2023	$165,730
2024	$178,162

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC) to mandate that MCOs providing services under Medicaid or the Children's Health Insurance Program (CHIP) reimburse retail and specialty pharmacies a minimum of the lesser of the reimbursement amount for the drug in the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program, 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 would also require MCOs to reimburse pharmacies that dispense a prescription drug at a discounted price under Section 340B of the Public Health Service Act not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program. The bill would require HHSC to conduct a study of Texas pharmacies' actual acquisition costs and dispensing cost at least every two years. The bill would take effect March 1, 2020.

Methodology

This analysis assumes implementation on January 1, 2021. Based on estimates provided by HHSC, this analysis assumes caseloads of 2,416,365 in fiscal year 2021, 3,993,270 in fiscal year 2022, 4,067,666 in fiscal year 2023, and 4,144,903 in fiscal year 2024, and pharmacy reimbursement that is 0.8 percent higher than under the current reimbursement model.

The net increased client services cost, including amounts for the Health Insurance Providers Fee, is estimated to be $22.8 million in All Funds, including $8.6 million in General Revenue, in fiscal year 2021, increasing to $36.9 million in All Funds, including $13.4 million in General Revenue, in fiscal year 2022 and continuing to increase to $42.6 million in fiscal year 2024, including $15.5 million in General Revenue.

This analysis assumes that any additional administrative costs to the MCOs or MCO pharmacy benefit managers for changes to the reimbursement methodology or to implement the required dispensing fees could be absorbed with existing resources.

The net increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures; resulting in assumed increased collections of $0.4 million in fiscal year 2021, $0.6 million in fiscal year 2022, and $0.7 million in fiscal year 2023 and fiscal year 2024. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission
LBB Staff: WP, AKi, EP, MDI

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

April 24, 2019

TO: Honorable Senfronia Thompson, Chair, House Committee on Public Health

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB3388** by Sheffield (Relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, Committee Report 1st House, Substituted: a negative impact of ($8,172,748) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	$0
2021	($8,172,748)
2022	($12,824,106)
2023	($13,781,188)
2024	($14,814,915)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Tobacco Receipts Match For Chip* 8025	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1
2020	$0	$0	$0	$0
2021	($8,293,500)	($259,883)	($13,457,091)	$285,476
2022	($12,992,796)	($448,192)	($21,809,439)	$462,661
2023	($13,962,467)	($481,642)	($23,437,110)	$497,191
2024	($15,009,792)	($517,770)	($25,195,129)	$534,485

Fiscal Year	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	$0
2021	$95,159
2022	$154,221
2023	$165,730
2024	$178,162

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC) to mandate that MCOs providing services under Medicaid or the Children's Health Insurance Program (CHIP) reimburse retail and specialty pharmacies a minimum of the lesser of the reimbursement amount for the drug in the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program, 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 would also require MCOs to reimburse pharmacies that dispense a prescription drug at a discounted price under Section 340B of the Public Health Service Act not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program. The bill would require HHSC to conduct a study of Texas pharmacies' actual acquisition costs and dispensing cost at least every two years. The bill would take effect March 1, 2020.

Methodology

This analysis assumes implementation on January 1, 2021. Based on estimates provided by HHSC, this analysis assumes caseloads of 2,416,365 in fiscal year 2021, 3,993,270 in fiscal year 2022, 4,067,666 in fiscal year 2023, and 4,144,903 in fiscal year 2024, and pharmacy reimbursement that is 0.8 percent higher than under the current reimbursement model.

The net increased client services cost, including amounts for the Health Insurance Providers Fee, is estimated to be $22.8 million in All Funds, including $8.6 million in General Revenue, in fiscal year 2021, increasing to $36.9 million in All Funds, including $13.4 million in General Revenue, in fiscal year 2022 and continuing to increase to $42.6 million in fiscal year 2024, including $15.5 million in General Revenue.

This analysis assumes that any additional administrative costs to the MCOs or MCO pharmacy benefit managers for changes to the reimbursement methodology or to implement the required dispensing fees could be absorbed with existing resources.

The net increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures; resulting in assumed increased collections of $0.4 million in fiscal year 2021, $0.6 million in fiscal year 2022, and $0.7 million in fiscal year 2023 and fiscal year 2024. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission
LBB Staff: WP, AKi, EP, MDI

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION
Revision 1

April 24, 2019

TO: Honorable Senfronia Thompson, Chair, House Committee on Public Health

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB3388** by Sheffield (Relating to delivery of outpatient prescription drug benefits under certain public benefit programs, including Medicaid and the child health plan program.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, As Introduced: a negative impact of ($10,203,431) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	$0
2021	($10,203,431)
2022	($3,536,883)
2023	($1,381,185)
2024	$615,078

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings from *GR Match For Medicaid* 758	Probable Savings from *Federal Funds* 555	Probable (Cost) from *GR Match For Medicaid* 758	Probable (Cost) from *Federal Funds* 555
2020	$0	$0	$0	$0
2021	$75,533,604	$119,772,778	($29,267,235)	($30,598,599)
2022	$119,070,153	$188,666,321	($44,118,334)	($45,384,132)
2023	$125,189,258	$198,367,682	($44,568,741)	($45,834,538)
2024	$131,691,687	$208,678,567	($45,402,907)	($46,668,705)

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	$0	$0	$0
2021	($432,800)	($42,027,750)	($14,009,250)
2022	($409,702)	($58,559,000)	($19,520,000)
2023	($409,702)	($61,194,000)	($20,398,000)
2024	($409,702)	($63,948,000)	($21,316,000)

Fiscal Year	Change in Number of State Employees from FY 2019
2020	0.0
2021	24.3
2022	24.3
2023	24.3
2024	24.3

Fiscal Analysis

The bill would amend Chapter 531 of the Government Code to require HHSC to provide outpatient prescription drug benefits through the vendor drug program using a fee-for-service delivery model to persons receiving benefits under Medicaid, the Children's Health Insurance Program, the kidney health care program, and any other benefit programs administered by HHSC that provide an outpatient prescription drug benefit. The bill would require HHSC to eliminate any obligation to pay fees included in the capitation rate or other amounts paid to managed care organizations (MCOs) associated with the provision of outpatient prescription drug benefits. The bill would require that if HHSC contracts with a claims processor to administer the outpatient prescription drug benefit program, HHSC would reimburse the claims administrator for the prescription drugs and a contracted administrative fee. The bill would require HHSC to consistently apply clinical prior authorization requirements statewide and use prior authorizations to control unnecessary utilization.

The bill would require HHSC to amend each contract with a MCO to prohibit the MCO from providing outpatient prescription drugs by December 31, 2019, and would prohibit an MCO from developing, implementing, or maintaining an outpatient pharmacy benefit plan for recipients beginning on the 180th day after the date HHSC begins providing outpatient prescription drug benefits. The bill would take effect September 1, 2019.

Methodology

This analysis assumes that the carve-out of outpatient prescription drug benefits from managed care would be implemented beginning January 1, 2021. This analysis assumes a 0.0 percent increase in utilization of pharmacy benefits based on provisions of the bill requiring HHSC to utilize prior authorizations to control unnecessary utilization.

Based on estimates provided by HHSC, this analysis assumes savings related to the Health Insurance Providers Fee under the federal Affordable Care Act and related federal income tax of $23,059,322 in General Revenue ($59,624,228 in All Funds) in fiscal year 2021, for which HHSC currently reimburses MCOs. The analysis also assumes other client services-related savings of

$52,474,281 in General Revenue ($135,682,153 in All Funds) in fiscal year 2021, due primarily to reduced expenditures for risk margin and insurance premium tax.

Savings are partially offset by assumed administrative costs of $1.80 per member per month, which results in an estimated cost of $28,235,148 in General Revenue ($56,470,295 in All Funds) beginning in fiscal year 2021 for contracted administrative fees that would be paid to the pharmacy claims processor. This analysis also assumes that HHSC will require 24.3 additional FTEs to manage increased workload associated with the carve-out of pharmacy benefits including additional contract requirements, policy development, review and determination of clinical PAs, and monitoring and sharing of data. This analysis assumes the costs related to the additional FTEs, including salaries and benefits, would be $1,106,547 in General Revenue ($3,116,931 in All Funds) in fiscal year 2021.

Based on estimates provided by HHSC, this analysis assumes one-time costs of $1,867,620 in General Revenue ($3,735,240 in All Funds) related to system modifications to HHSC's existing pharmacy benefits system to implement the provisions of the bill. This analysis also assumes an ongoing cost of $353,068 in General Revenue ($706,137 in All Funds) beginning in fiscal year 2020 related to expansion of contracted call center services.

The decrease in client services payments through managed care are assumed to result in a decrease in insurance premium tax revenue. This analysis assumes a decrease in collections of $56.0 million in fiscal year 2021, $78.1 million in fiscal year 2022, $81.6 million in fiscal year 2023, and $85.3 million in fiscal year 2024 based on estimates provided by the Comptroller of Public Accounts, adjusted for the assumed implementation date of January 1, 2021. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

Technology

Technology costs are expected to be $4,441,377 in fiscal year 2020 and $851,208 in fiscal year 2021.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 304 Comptroller of Public Accounts, 529 Health and Human Services Commission

LBB Staff: WP, AKi, EP, MDI, SD

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

April 3, 2019

TO: Honorable Senfronia Thompson, Chair, House Committee on Public Health

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB3388** by Sheffield (Relating to delivery of outpatient prescription drug benefits under certain public benefit programs, including Medicaid and the child health plan program.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, As Introduced: a negative impact of ($102,740,986) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	($73,719,689)
2021	($29,021,297)
2022	($3,775,378)
2023	($1,635,515)
2024	$343,911

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *GR Match For Title XXI* 8010	Probable Savings/(Cost) from *GR Match for Food Stamp Admin* 8014
2020	$0	($2,220,689)	$0	$0
2021	($430,164)	$46,127,503	($64)	($2,572)
2022	($407,248)	$74,713,324	($60)	($2,394)
2023	($407,248)	$80,366,187	($60)	($2,394)
2024	($407,248)	$86,017,613	($60)	($2,394)

Fiscal Year	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	($2,220,689)	($53,624,000)	($17,875,000)
2021	$89,318,316	($56,037,000)	($18,679,000)
2022	$143,520,684	($58,559,000)	($19,520,000)
2023	$152,787,474	($61,194,000)	($20,398,000)
2024	$162,281,028	($63,948,000)	($21,316,000)

Fiscal Year	Change in Number of State Employees from FY 2019
2020	24.3
2021	24.3
2022	24.3
2023	24.3
2024	24.3

Fiscal Analysis

The bill would amend Chapter 531 of the Government Code to require HHSC to provide outpatient prescription drug benefits through the vendor drug program using a fee-for-service delivery model to persons receiving benefits under Medicaid, the Children's Health Insurance Program, the kidney health care program, and any other benefit programs administered by HHSC that provide an outpatient prescription drug benefit. The bill would require HHSC to eliminate any obligation to pay fees included in the capitation rate or other amounts paid to managed care organizations (MCOs) associated with the provision of outpatient prescription drug benefits. The bill would require that if HHSC contracts with a claims processor to administer the outpatient prescription drug benefit program, HHSC would reimburse the claims administrator for the prescription drugs and a contracted administrative fee. The bill would require HHSC to consistently apply clinical prior authorization requirements statewide and use prior authorizations to control unnecessary utilization.

The bill would require HHSC to amend each contract with an MCO to prohibit the MCO from providing outpatient prescription drugs by December 31, 2019, and would prohibit an MCO from developing, implementing, or maintaining an outpatient pharmacy benefit plan for recipients beginning on the 180th day after the date HHSC begins providing outpatient prescription drug benefits. The bill would take effect September 1, 2019.

Methodology

This analysis assumes that the carve-out of outpatient prescription drug benefits from managed care would be implemented beginning January 1, 2020. This analysis assumes a 0.0 percent increase in utilization of pharmacy benefits based on provisions of the bill requiring HHSC to utilize prior authorizations to control unnecessary utilization.

Based on estimates provided by HHSC, this analysis assumes savings related to the Health Insurance Providers Fee under the federal Affordable Care Act and related federal income tax of $23,059,322 in General Revenue ($59,624,228 in All Funds) in fiscal year 2021, for which HHSC currently reimburses MCOs. The analysis also assumes other client services-related savings of

$51,735,605 in General Revenue ($135,682,153 in All Funds) in fiscal year 2021, due primarily to reduced risk margin costs.

Savings are partially offset by assumed administrative costs of $1.80 per member per month, which results in an estimated cost of $28,235,148 in General Revenue ($56,470,295 in All Funds) in fiscal year 2021 for contracted administrative fees that would be paid to the pharmacy claims processor. This analysis also assumes that HHSC will require 24.3 additional FTEs to manage increased workload associated with the carve-out of pharmacy benefits including additional contract requirements, policy development, review and determination of clinical PAs, and monitoring and sharing of data. This analysis assumes the costs related to the additional FTEs, including salaries and benefits, would be $1,106,547 in General Revenue ($3,116,931 in All Funds) in fiscal year 2021.

Based on estimates provided by HHSC, this analysis assumes one-time costs of $1,867,620 in General Revenue ($3,735,240 in All Funds) related to system modifications to HHSC's existing pharmacy benefits system to implement the provisions of the bill. This analysis also assumes an ongoing cost of $353,068 in General Revenue ($706,137 in All Funds) beginning in fiscal year 2020 related to expansion of contracted call center services.

The Comptroller of Public Accounts estimates a loss of $71,499,000 in fiscal year 2020 and $74,716,000 in fiscal year 2021 from insurance premium taxes as a result of reductions to capitation payments made to managed care organizations. CPA indicates that entities that are subject to insurance premium tax are required to prepay tax semi-annually, and the analysis assumes that MCOs will reduce their insurance premium tax prepayments in fiscal year 2020 in amounts proportional to the decrease in capitation payments anticipated for fiscal year 2021.

Technology

Technology costs are expected to be $4,441,377 in fiscal year 2020 and $851,208 in fiscal year 2021.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 304 Comptroller of Public Accounts, 529 Health and Human Services Commission

LBB Staff: WP, AKi, EP, MDI