BILL ANALYSIS

Senate Research Center
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H.B. 3388
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Maximum allowable cost (MAC) is the highest amount a managed care organization (MCO) and/or pharmacy benefit manager (PBM) will pay a pharmacy for a specific drug.

H.B. 3388 removes the current maximum allowable cost requirement and replaces it with a new reimbursement methodology that the MCO or PBM must comply with as a condition of contract retention and renewal with the Health and Human Services Commission.

H.B. 3388 requires an MCO/PBM reimbursement for prescription drugs to be tied to the National Average Drug Acquisition Cost (NADAC) methodology to provide pharmacists and the public with a clear and transparent system for the reimbursement of prescription drugs in Medicaid.

H.B. 3388 amends current law relating to the reimbursement of prescription drugs under Medicaid and the child health plan program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commission) in SECTION 2 (Section 533.00514, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

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

> (a) Makes nonsubstantive changes. Requires a contract between a managed care organization and the Health and Human Services Commission (HHSC) for the organization to provide health care services to recipients to contain:
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> > (1)–(22) makes no changes to these subdivisions;
> >
> > (23) subject to Subsection (a-1) (relating to providing that requirements imposed by Subsections (a)(23)(A), (B), and (C) do not apply, and are prohibited from being enforced, on and after August 31, 2023), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:
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> > > (A)-(J) makes no changes to these paragraphs;
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> > > (K) under which the managed care organization or pharmacy benefit manager, as applicable:
> > >
> > > > (i) is required to comply with Section 533.00514 as a condition of contract retention and renewal, rather than to place a drug on a maximum allowable cost list, is required to ensure that the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's (FDA) 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 the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) is required to review and update drug reimbursement price information at least once every seven days to reflect any modification of pricing under the vendor drug program, rather than is required to 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 review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

(iii) deletes existing text that requires the managed care organization to, 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 FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, 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. Requires the managed care organization to:

(a) provide a procedure under which a network pharmacy provider is authorized to challenge the reimbursement price for a drug, rather than provide a procedure under which a network pharmacy provider is authorized to challenge a listed maximum allowable cost price for a drug;

(b)-(d) makes no changes to these paragraphs;

(e) report to HHSC every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each drug for which a challenge was denied during the period, rather than report to HHSC 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) is required to provide a process for each of its network pharmacy providers to readily access the drug reimbursement price list specific to that provider, rather than is required to notify HHSC 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 provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider;

(24) makes no changes to this subdivision;

(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) (relating to providing that, for purposes of Subsection (a)(25)(A), a provider reimbursement rate reduction is considered to have received HHSC's prior approval unless HHSC issues a written statement of disapproval not later than the 45th day after the date HHSC receives notice of the proposed rate reduction from the managed care organization), the organization has the prior approval of HHSC to make the reductions; or

(B) makes no changes to this paragraph; and

(26) makes no changes to this subdivision.

Redesignates Subparagraph (iii) as Subparagraph (ii). Redesignates Subparagraphs (v)-(vi) as Subparagraph (iv).

SECTION 2. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00514, as follows:

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. (a) Requires a managed care organization that contracts with HHSC under this chapter (Medically Managed Care Program) or a pharmacy benefit manager administering a pharmacy benefit program on behalf of the managed care organization, in accordance with rules adopted by the executive commissioner of HHSC (executive commissioner), to 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;

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

(c) Requires the executive commissioner to develop a process for the periodic study of Texas retail pharmacies' AAC for prescription drugs, Texas specialty pharmacies' AAC for prescription drugs, retail professional dispensing costs, and specialty pharmacy professional dispensing costs and publish the results of each study on HHSC's Internet website.

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

(1) Subsection (a)(1) are required to 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) are required to be based on Texas pharmacies' professional dispensing costs for those drugs.

(e) Requires HHSC, not less frequently than once every two years, to 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). Requires the executive commissioner, based on the results of the study, to 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. Amends Subchapter D, Chapter 62, Health and Safety Code, by adding Section 62.160, as follows:

Sec. 62.160. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS. Requires 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 Section 533.00514, Government Code.

SECTION 4. Repealer: Section 533.005(a-2) (relating to providing that, except as provided by Subsection (a)(23)(K)(viii), a maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefit manager is confidential), Government Code.

SECTION 5. Requires the agency affected by the provision, 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, to request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 6. Effective date: March 1. 2020.