CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

5/25/2019
Date

Honorable Dan Patrick
President of the Senate

Honorable Dennis Bonnen
Speaker of the House of Representatives

Sirs:

We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on HB 3388 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

On the part of the Senate	On the part of the House
Kolkhorst	Sheffield
Bettencourt	Lucio III
Hughes	Price
Johnson	Raymond
Perry	Zerwas

Note to Conference Committee Clerk:

Please type the names of the members of the Conference Committee under the lines provided for signature. Those members desiring to sign the report should sign each of the six copies. Attach a copy of the Conference Committee Report and a Section by Section side by side comparison to each of the six reporting forms. The original and two copies are filed in house of origin of the bill, and three copies in the other house.

CONFERENCE COMMITTEE REPORT

3rd Printing

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, if applicable [~~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).

(f) Notwithstanding any other provision of this section and subject to Subsection (g), the executive commissioner by rule may reduce the minimum dispensing fee required under Subsections (a) and (d) by an amount not to exceed 85 cents. The commission may implement the minimum fee amount only after publishing the rule adopting the amount.

(g) The commission shall promptly implement changes to the preferred drug list as recommended by the Drug Utilization Review Board to fully realize potential savings caused by generic drug

deflation. If the executive commissioner identifies savings as a result of the changes implemented under this subsection, the executive commissioner may increase the minimum dispensing fee established under Subsection (f), subject to Subsections (a) and (d).

(h) This section expires September 1, 2023.

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. This section expires September 1, 2023.

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 Section 533.005(a-2), Government Code, is repealed.

SECTION 5. (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. In quantifying the impact of this Act that results from changes to the National Average Drug Acquisition Cost reference pricing reimbursement model on the state's utilization and cost, the commission shall include the true deflation of generic drugs over the three preceding state fiscal years, as determined under the

National Average Drug Acquisition Cost, as compared to amounts actually reported. The report must include an analysis and comparison of drug price inflation or 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.

SECTION 6. (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 the 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 by 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.

SECTION 7. 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 8. This Act takes effect March 1, 2020.

House Bill 3388
Conference Committee Report
Section-by-Section Analysis

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
SECTION 1. Section 533.005(a), Government Code, is amended. Among other provisions, Subparagraph (a)(23)(K)(i) is amended 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: … (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: … (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~~];	SECTION 1. Same as House version except 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: … (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: … (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, ***if applicable*** [~~to place a drug on a maximum allowable cost list, must ensure that:~~ [FA1(1)] [~~(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~~];	SECTION 1. Same as Senate version.

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00514 as follows:	SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00514 as follows:	SECTION 2. Same as Senate version except as follows:
Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.	Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.	Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.
(a)-(e)	(a)-(e) Same as House version.	(a)-(e) Same as House version.
No equivalent provision.	(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.	(f) Notwithstanding any other provision of this section ***and subject to Subsection (g)***, the executive commissioner by rule may ***reduce the*** minimum dispensing fee required under Subsections (a) and (d) ***by an amount not to exceed 85 cents. The commission*** may implement the minimum fee amount only after publishing the rule ***adopting the amount***.
No equivalent provision.	(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.	Same as House version.
No equivalent provision.	Same as House version.	(g) The commission shall promptly implement changes to the preferred drug list as recommended by the Drug Utilization Review Board to fully realize potential savings caused by generic drug deflation. If the executive commissioner identifies savings as a result of the changes implemented under this subsection, the executive

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
		commissioner may increase the minimum dispensing fee established under Subsection (f), subject to Subsections (a) and (d). [*The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.*]
No equivalent provision.	(h) This section expires September 1, 2023. [FA1(2)]	(h) Same as Senate version.
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 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. ***This section expires September 1, 2023.*** [FA1(3)]	SECTION 3. Same as Senate version.
SECTION 4. Section 533.005(a-2), Government Code, is repealed.	SECTION 4. Same as House version.	SECTION 4. Same as House version.
No equivalent provision.	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	SECTION 5. (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

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
	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.	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. ***In quantifying the impact of this Act that results from changes to the National Average Drug Acquisition Cost reference pricing reimbursement model on the state's utilization and cost, the commission shall include the true deflation of generic drugs over the three preceding state fiscal years, as determined under the National Average Drug Acquisition Cost, as compared to amounts actually reported.*** The report must include an analysis and comparison of drug price ***inflation or*** 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.).
	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.
	(b) This section expires September 1, 2023. [FA1(5)]	[*The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.*]
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 __. (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***	SECTION 6. Substantially the same as Senate version.

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
	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. [FA1(4)]***	
No equivalent provision.	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. Same as Senate version.
SECTION 6. This Act takes effect March 1, 2020.	SECTION 7. Same as House version.	SECTION 8. Same as House version.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 25, 2019

TO: Honorable Dan Patrick, Lieutenant Governor, Senate
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.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3388, Conference Committee Report: 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 reduce the minimum dispensing fee by up to 85 cents in certain circumstances after publishing the rule adopting the amount. The bill would require the Executive Commissioner of HHSC to increase a reduced minimum dispensing fee if the Executive Commissioner identifies savings as a result of implementing changes to the preferred drug list to realize potential savings caused by generic drug deflation. The cost estimates discussed below could change significantly depending upon the amount of the actual 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

Certification of Compliance with
Rule 13, Section 6(b), House Rules of Procedure

Rule 13, Section 6(b), House Rules of Procedure, requires a copy of a conference committee report signed by a majority of each committee of the conference to be furnished to each member of the committee in person or, if unable to deliver in person, by placing a copy in the member's newspaper mailbox at least one hour before the report is furnished to each member of the house under House Rule 13, Section 10(a). The paper copies of the report submitted to the chief clerk under Rule 13, Section 10(b), must contain a certificate that the requirement of Rule 13, Section 6(b), has been satisfied, and that certificate must be attached to the copy of the report furnished to each member under Rule 13, Section 10(d). Failure to comply with this requirement is not subject to a point of order under Rule 13.

I certify that a copy of the conference committee report on HB 3388 was furnished to each member of the conference committee in compliance with Rule 13, Section 6(b), House Rules of Procedure, before submission of the paper copies of the report to the chief clerk under Rule 13, Section 10(b), House Rules of Procedure.

JD Sheffield
J.D. Sheffield
(name)

May 25, 2017
(date)