

# CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

5/25/2019

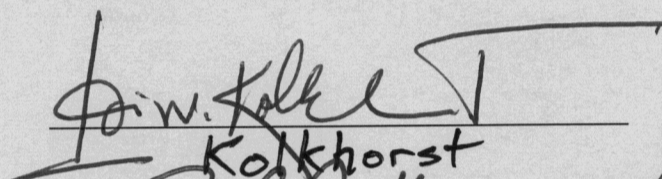
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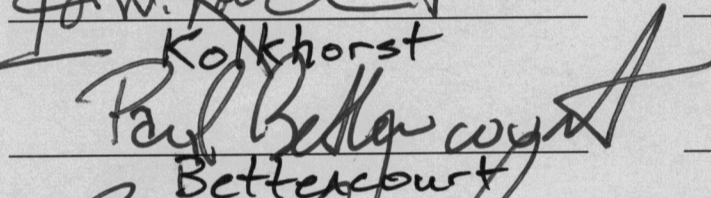
Honorable Dan Patrick  
President of the Senate

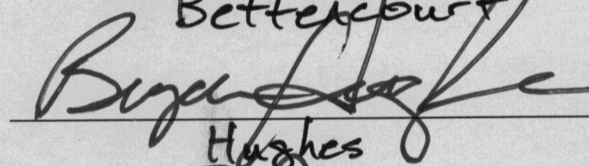
Honorable Dennis Bonnen  
Speaker of the House of Representatives

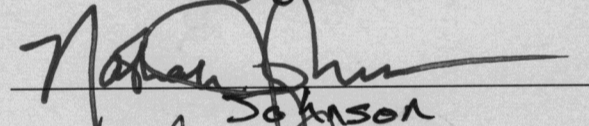
Sirs:

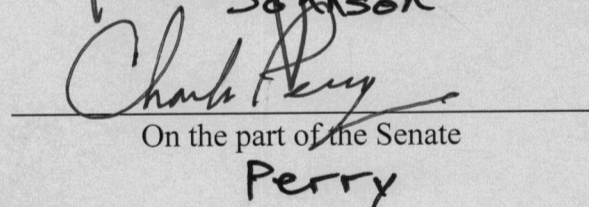
We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on HB 3388 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

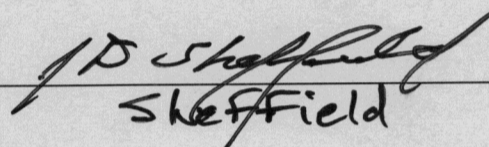
  
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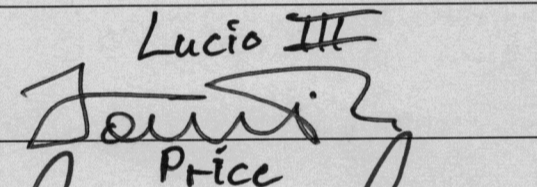
  
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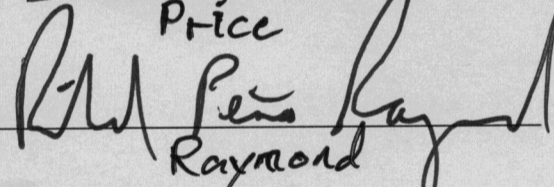
  
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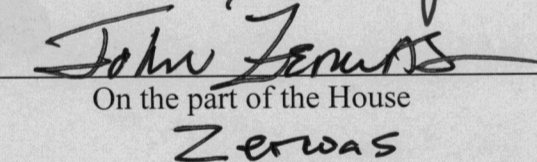
  
Johnson

  
On the part of the Senate  
Perry

  
Sheffield

Lucio III  
  
Price

  
Raymond

  
On the part of the House  
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

3<sup>rd</sup> 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;

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

5           (6) procedures for recipient outreach and education;

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

11           (A) not later than:

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

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

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

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

24           (7-a) a requirement that the managed care organization  
25 demonstrate to the commission that the organization pays claims  
26 described by Subdivision (7)(A)(ii) on average not later than the  
27 21st day after the date the claim is received by the organization;

1           (8) a requirement that the commission, on the date of a  
2 recipient's enrollment in a managed care plan issued by the managed  
3 care organization, inform the organization of the recipient's  
4 Medicaid certification date;

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

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

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

17           (12) if the commission finds that a managed care  
18 organization has violated Subdivision (11), a requirement that the  
19 managed care organization reimburse an out-of-network provider for  
20 health care services at a rate that is equal to the allowable rate  
21 for those services, as determined under Sections 32.028 and  
22 32.0281, Human Resources Code;

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

26                   (A) use advanced practice registered nurses and  
27 physician assistants in addition to physicians as primary care

1 providers to increase the availability of primary care providers in  
2 the organization's provider network; and

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

6 (i) selection and assignment as primary  
7 care providers;

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

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

12 (14) a requirement that the managed care organization  
13 reimburse a federally qualified health center or rural health  
14 clinic for health care services provided to a recipient outside of  
15 regular business hours, including on a weekend day or holiday, at a  
16 rate that is equal to the allowable rate for those services as  
17 determined under Section 32.028, Human Resources Code, if the  
18 recipient does not have a referral from the recipient's primary  
19 care physician;

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

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

26 (B) the contracting with physicians who are not  
27 network providers and who are of the same or related specialty as

1 the appealing physician to resolve claims disputes related to  
2 denial on the basis of medical necessity that remain unresolved  
3 subsequent to a provider appeal;

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

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

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

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

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

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

26 (20) a requirement that the managed care organization:  
27 (A) develop and submit to the commission, before

1 the organization begins to provide health care services to  
2 recipients, a comprehensive plan that describes how the  
3 organization's provider network complies with the provider access  
4 standards established under Section 533.0061;

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

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

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

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

17 (D) regularly, as determined by the commission,  
18 submit to the commission and make available to the public a report  
19 containing data on the sufficiency of the organization's provider  
20 network with regard to providing the care and services described  
21 under Section 533.0061(a) and specific data with respect to access  
22 to primary care, specialty care, long-term services and supports,  
23 nursing services, and therapy services on the average length of  
24 time between:

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

1                   (ii) the date the organization approves a  
2 request for prior authorization for the care or service and the date  
3 the care or service is initiated;

4                   (21) a requirement that the managed care organization  
5 demonstrate to the commission, before the organization begins to  
6 provide health care services to recipients, that, subject to the  
7 provider access standards established under Section 533.0061:

8                   (A) the organization's provider network has the  
9 capacity to serve the number of recipients expected to enroll in a  
10 managed care plan offered by the organization;

11                   (B) the organization's provider network  
12 includes:

13                               (i) a sufficient number of primary care  
14 providers;

15                               (ii) a sufficient variety of provider  
16 types;

17                               (iii) a sufficient number of providers of  
18 long-term services and supports and specialty pediatric care  
19 providers of home and community-based services; and

20                               (iv) providers located throughout the  
21 region where the organization will provide health care services;  
22 and

23                   (C) health care services will be accessible to  
24 recipients through the organization's provider network to a  
25 comparable extent that health care services would be available to  
26 recipients under a fee-for-service or primary care case management  
27 model of Medicaid managed care;

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

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

8                   (B) focuses on measuring outcomes; and

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

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

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

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

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

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

26                           (i) may not negotiate or collect rebates  
27 associated with pharmacy products on the vendor drug program

1   formulary; and

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

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

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

11                              (G)   that allows the managed care organization or  
12  any subcontracted pharmacy benefit manager to contract with a  
13  pharmacist or pharmacy providers separately for specialty pharmacy  
14  services, except that:

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

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

26                              (H)   under which the managed care organization may  
27  not prevent a pharmacy or pharmacist from participating as a

1 provider if the pharmacy or pharmacist agrees to comply with the  
2 financial terms and conditions of the contract as well as other  
3 reasonable administrative and professional terms and conditions of  
4 the contract;

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

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

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

15 (i) must comply with Section 533.00514 as a  
16 condition of contract retention and renewal, if applicable ~~[to~~  
17 ~~place a drug on a maximum allowable cost list, must ensure that:~~

18 ~~[(a) the drug is listed as "A" or "B"~~  
19 ~~rated in the most recent version of the United States Food and Drug~~  
20 ~~Administration's Approved Drug Products with Therapeutic~~  
21 ~~Equivalence Evaluations, also known as the Orange Book, has an "NR"~~  
22 ~~or "NA" rating or a similar rating by a nationally recognized~~  
23 ~~reference, and~~

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

27 (ii) must ~~[provide to a network pharmacy~~

1 ~~provider, at the time a contract is entered into or renewed with the~~  
2 ~~network pharmacy provider, the sources used to determine the~~  
3 ~~maximum allowable cost pricing for the maximum allowable cost list~~  
4 ~~specific to that provider,~~

5                   ~~[(iii) must]~~ review and update drug  
6 reimbursement ~~[maximum allowable cost]~~ price information at least  
7 once every seven days to reflect any modification of ~~[maximum~~  
8 ~~allowable cost]~~ pricing under the vendor drug program;

9                   ~~(iii)~~ ~~[(iv) must, in formulating the~~  
10 ~~maximum allowable cost price for a drug, use only the price of the~~  
11 ~~drug and drugs listed as therapeutically equivalent in the most~~  
12 ~~recent version of the United States Food and Drug Administration's~~  
13 ~~Approved Drug Products with Therapeutic Equivalence Evaluations,~~  
14 ~~also known as the Orange Book,~~

15                   ~~[(v) must establish a process for~~  
16 ~~eliminating products from the maximum allowable cost list or~~  
17 ~~modifying maximum allowable cost prices in a timely manner to~~  
18 ~~remain consistent with pricing changes and product availability in~~  
19 ~~the marketplace,~~

20                   ~~[(vi)]~~ must:

21                   (a) provide a procedure under which a  
22 network pharmacy provider may challenge the reimbursement ~~[a listed~~  
23 ~~maximum allowable cost]~~ price for a drug;

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

26                   (c) if the challenge is successful,  
27 make an adjustment in the drug price effective on the date the

1 challenge is resolved, and make the adjustment applicable to all  
2 similarly situated network pharmacy providers, as determined by the  
3 managed care organization or pharmacy benefit manager, as  
4 appropriate;

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

7 (e) report to the commission every 90  
8 days the total number of challenges that were made and denied in the  
9 preceding 90-day period for each [~~maximum allowable cost list~~] drug  
10 for which a challenge was denied during the period; and

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

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

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

26 (25) a requirement that the managed care organization  
27 not implement significant, nonnegotiated, across-the-board

1 provider reimbursement rate reductions unless:

2 (A) subject to Subsection (a-3), the  
3 organization has the prior approval of the commission to make the  
4 reductions [~~reduction~~]; or

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

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

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

13 Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION  
14 DRUGS. (a) In accordance with rules adopted by the executive  
15 commissioner, a managed care organization that contracts with the  
16 commission under this chapter or a pharmacy benefit manager  
17 administering a pharmacy benefit program on behalf of the managed  
18 care organization shall reimburse a pharmacy or pharmacist,  
19 including a Texas retail pharmacy or a Texas specialty pharmacy,  
20 that:

21 (1) dispenses a prescribed prescription drug, other  
22 than a drug obtained under Section 340B, Public Health Service Act  
23 (42 U.S.C. Section 256b), to a recipient for not less than the  
24 lesser of:

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

1 or

2 (B) the amount claimed by the pharmacy or  
3 pharmacist, including the gross amount due or the usual and  
4 customary charge to the public for the drug; or

5 (2) dispenses a prescribed prescription drug obtained  
6 at a discounted price under Section 340B, Public Health Service Act  
7 (42 U.S.C. Section 256b) to a recipient for not less than the  
8 reimbursement amount for the drug under the vendor drug program,  
9 including a dispensing fee that is not less than the dispensing fee  
10 for the drug under the vendor drug program.

11 (b) The methodology adopted by rule by the executive  
12 commissioner to determine Texas pharmacies' actual acquisition  
13 cost (AAC) for purposes of the vendor drug program must be  
14 consistent with the actual prices Texas pharmacies pay to acquire  
15 prescription drugs marketed or sold by a specific manufacturer and  
16 must be based on the National Average Drug Acquisition Cost  
17 published by the Centers for Medicare and Medicaid Services or  
18 another publication approved by the executive commissioner.

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

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

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

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

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

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

9           (e) Not less frequently than once every two years, the  
10 commission shall conduct a study of Texas pharmacies' dispensing  
11 costs for retail prescription drugs, specialty prescription drugs,  
12 and drugs obtained under Section 340B, Public Health Service Act  
13 (42 U.S.C. Section 256b). Based on the results of the study, the  
14 executive commissioner shall adjust the minimum amount of the  
15 retail professional dispensing fee and specialty pharmacy  
16 professional dispensing fee under Subsection (a)(1) and the  
17 dispensing fee for drugs obtained under Section 340B, Public Health  
18 Service Act (42 U.S.C. Section 256b).

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

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

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

6 (h) This section expires September 1, 2023.

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

9 Sec. 62.160. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION  
10 DRUGS. A managed care organization providing pharmacy benefits  
11 under the child health plan program or a pharmacy benefit manager  
12 administering a pharmacy benefit program on behalf of the managed  
13 care organization shall comply with Section 533.00514, Government  
14 Code. This section expires September 1, 2023.

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

17 SECTION 5. (a) Not later than December 31, 2022, the Health  
18 and Human Services Commission shall submit a report to the  
19 legislature on the impact of this Act on and the changes made to  
20 prescription drug pricing and reimbursement under the Medicaid  
21 managed care program under Chapter 533, Government Code, and the  
22 child health plan program under Chapter 62, Health and Safety Code.  
23 In quantifying the impact of this Act that results from changes to  
24 the National Average Drug Acquisition Cost reference pricing  
25 reimbursement model on the state's utilization and cost, the  
26 commission shall include the true deflation of generic drugs over  
27 the three preceding state fiscal years, as determined under the

1 National Average Drug Acquisition Cost, as compared to amounts  
2 actually reported. The report must include an analysis and  
3 comparison of drug price inflation or deflation, professional fees,  
4 and trends in other public benefits programs, including Medicare  
5 under Title XVIII of the Social Security Act (42 U.S.C. Section 1395  
6 et seq.).

7 (b) This section expires September 1, 2023.

8 SECTION 6. (a) If before implementing a provision of this  
9 Act a state agency determines that a waiver or authorization from a  
10 federal agency is necessary for implementation of that provision,  
11 the agency affected by the provision shall request the waiver or  
12 authorization and may delay implementing all provisions of this Act  
13 until the waiver or authorization is granted.

14 (b) Notwithstanding any other provision of this Act:

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

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

24 SECTION 7. The Health and Human Services Commission is  
25 required to implement a provision of this Act only if the  
26 legislature appropriates money specifically for that purpose. If  
27 the legislature does not appropriate money specifically for that

H.B. No. 3388

1 purpose, the Health and Human Services Commission may, but is not  
2 required to, implement a provision of this Act using other  
3 appropriations available for that purpose.

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

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

HOUSE VERSION

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];~~

SENATE VERSION (IE)

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];~~

CONFERENCE

SECTION 1. Same as Senate version.

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

HOUSE VERSION

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

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.

(a)-(e)

*No equivalent provision.*

*No equivalent provision.*

*No equivalent provision.*

SENATE VERSION (IE)

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

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.

(a)-(e) Same as House version.

(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.

Same as House version.

CONFERENCE

SECTION 2. Same as Senate version except as follows:

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.

(a)-(e) Same as House version.

(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*.

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

HOUSE VERSION

SENATE VERSION (IE)

CONFERENCE

*No equivalent provision.*

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.

*No equivalent provision.*

(h) This section expires September 1, 2023. [FA1(2)]

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 4. Same as House version.

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

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.]

(h) Same as Senate version.

SECTION 3. Same as Senate version.

SECTION 4. Same as House version.

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

HOUSE VERSION

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. [FA1(5)]

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*

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. *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.

*[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 6. Substantially the same as Senate version.

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

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. [FAI(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:**

<b>Fiscal Year</b>	<b>Probable Net Positive/(Negative) Impact to General Revenue Related Funds</b>
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 <i>GR Match For Medicaid</i> 758	Probable Savings/(Cost) from <i>Tobacco Receipts Match For Chip</i> 8025	Probable Savings/(Cost) from <i>Federal Funds</i> 555	Probable Revenue Gain/(Loss) from <i>General Revenue Fund</i> 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 <i>Foundation School Fund</i> 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.

(name)

J.D. Sheffield  
J.D. Sheffield

(date)

MAY 25, 2017