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, the 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
Perry

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.
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;
H.B. No. 3388

(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;
H.B. No. 3388

(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
provides 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
H.B. No. 3388

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

86R37176 KFP-D 10
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;

(iv) 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;

(iv) 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; 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:
H.B. No. 3388

(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
H.B. No. 3388

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 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:

[(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.

(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.

No equivalent provision.

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 (a), 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.

Same as House version.

Associated CCR Draft: 86R37176

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 and subject to Subsection (a), 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.

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 (a), 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.

Same as House version.

Sec. 533.00514. REIMBURSEMENT METHODOLOGY FOR PRESCRIPTION DRUGS.

(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

19.145.627
House Bill 3388
Conference Committee Report
Section-by-Section Analysis

HOUSE VERSION

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.

SENATE VERSION (IE)

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

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. This section expires September 1, 2023. [FA1(3)]

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.]

(b) Same as Senate version.

SECTION 3. Same as Senate version.

SECTION 4. Same as House 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

Associated CCR Draft: 86R37176

3

19.145.627
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

[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.
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. [PAI(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 6. This Act takes effect March 1, 2020.

SECTION 7. Same as Senate version.

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  

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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:  

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Probable Net Positive/(Negative) Impact to General Revenue Related Funds</th>
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<tbody>
<tr>
<td>2020</td>
<td>$0</td>
</tr>
<tr>
<td>2021</td>
<td>($8,172,748)</td>
</tr>
<tr>
<td>2022</td>
<td>($12,824,106)</td>
</tr>
<tr>
<td>2023</td>
<td>($13,781,188)</td>
</tr>
<tr>
<td>2024</td>
<td>($14,814,915)</td>
</tr>
</tbody>
</table>
### All Funds, Five-Year Impact:

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

### 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.

\[Signature\]

(name)

\[Date\]

(date)