HB 589

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 589 (Delegate Barron, *et al.*)
Health and Government Operations Finance

Maryland Medical Assistance Program and Managed Care Organizations That Use Pharmacy Benefits Managers – Audit and Professional Dispensing Fees

This emergency bill requires Medicaid to contract with an independent auditor for an audit of pharmacy benefits managers (PBMs) that contract with Medicaid managed care organizations (MCOs). The auditor must be provided with access to specified documents and information. By December 1, 2019, Medicaid must provide the results of the audit to the General Assembly. By January 1, 2020, the Maryland Department of Health (MDH), in consultation with the Maryland Insurance Administration (MIA), must develop recommendations for an appeals process for decisions made in accordance with contracts between a PBM and an MCO and report the recommendations to the General Assembly. By July 1, 2020, MDH *may* apply for a federal waiver, subject to the limitations of the State budget, to provide professional dispensing fees or other measures for pharmacies to ensure access to pharmacy services. **The bill's waiver provisions terminate July 1, 2021.**

Fiscal Summary

State Effect: The bill's requirements can likely be handled with existing budgeted resources, as discussed below. Federal fund matching revenues increase if additional Medicaid expenditures are incurred.

Local Effect: None.

Small Business Effect: Potential meaningful.

Analysis

Current Law: A PBM is a business that administers and manages prescription drug benefit plans for purchasers. A PBM must register with MIA prior to providing pharmacy benefits management services. The Insurance Commissioner is authorized to examine the affairs, transactions, accounts, and records of a registered PBM at the PBM's expense.

Each contract between a PBM and a contracted pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost (MAC) pricing. This process must meet several requirements. An appeal must be filed by the contract pharmacy no later than 21 days after the date of the initial adjudicated claim. Within 21 days after the date the appeal is filed, the PBM must investigate and resolve the appeal and report to the contracted pharmacy on the PBM's determination. A PBM must make available on its website specified information about the appeals process. A PBM must provide, in addition to a reason for any appeal denial, the national drug code of a drug and the name of the wholesale distributor from which the drug was available on the date the claim was adjudicated at a price at or below the MAC determined by the PBM. If an appeal is upheld, a PBM must, for the appealing pharmacy, adjust the MAC in a specified manner and provide specified reimbursement for claims and, for a similarly situated contracted pharmacy in the State, adjust the MAC in a specified manner and provide specified notice of the contracted pharmacy's right to reverse and rebill specified claims. A PBM may not retaliate against a contracted pharmacy for exercising its right to appeal a MAC price or filing a complaint with the Commissioner. A PBM may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from an appeal related to MAC pricing.

If a PBM denies an appeal and a contracted pharmacy files a complaint with the Commissioner, the Commissioner must (1) review the compensation program of the PBM to ensure that the reimbursement paid to the pharmacist or pharmacy complies with specified law and the terms of the contract and (2) based on this determination, dismiss the appeal or uphold the appeal and order the PBM to pay the claim or claims in accordance with the Commissioner's findings. All pricing information and data collected by the Commissioner during such a review is confidential and proprietary and not subject to disclosure under the Public Information Act.

Background: Outpatient pharmacy coverage is an optional benefit under Medicaid. Reimbursement for prescription drugs varies between fee-for-service (FFS) Medicaid (which covers about 15% of Medicaid enrollees) and HealthChoice (under which Medicaid MCOs cover about 85% of Medicaid enrollees).

In FFS, Medicaid reimburses pharmacies based on a two-part formula consisting of the ingredient cost of the drug and the professional dispensing fee. Effective April 2017,

Maryland adopted the National Average Drug Acquisition Cost (NADAC) methodology to calculate the ingredient cost of the drug. This methodology estimates the national average drug invoice price paid by independent and retail chain pharmacies. For any drug not included in NADAC, the State uses its own State actual acquisition cost (SAAC) as a secondary benchmark. Thus, for FFS pharmacy expenditures, Medicaid reimburses pharmacies as follows:

- the ingredient cost of the drug based on NADAC or a provider's usual and customary charges, whichever is lower; if there is no NADAC, the lowest of the wholesale acquisition cost, the federal upper limit, SAAC, or a provider's usual and customary charges; and

- a professional dispensing fee of $10.49 for brand name and generic drugs or $11.49 for drugs dispensed to nursing home patients.

In HealthChoice, all nine Medicaid MCOs use a PBM. PBM reimbursement amounts are proprietary and confidential. However, narrative in the 2018 *Joint Chairmen's Report* requested that MDH report on various aspects of pharmacy reimbursement. MDH's response summarized MCO PBM costs for a sample of drugs according to a low, high, and average rate across all MCOs.

The report noted that the FFS average ingredient cost per unit was lower than the MCO average ingredient cost per unit for 37 of the drugs analyzed. However, the professional dispensing fees paid by MCOs were much lower than those paid under FFS. Of the drugs sampled, only three had higher MCO dispensing fees than the FFS rate, and the average dispensing fee paid by MCOs across the sample was only $2.63.

State Fiscal Effect: Medicaid advises that it can likely absorb the cost of a contract with an independent auditor as required under the bill using existing budgeted resources. However, as the bill does not specify the scope of the required audit, Medicaid plans to contract for an audit that includes two years of data for all nine MCOs and their respective PBMs. To the extent the audit includes additional data over a greater time period, Medicaid expenditures increase, in fiscal 2020 only, by an indeterminate amount. Any Medicaid expenditures for an audit contract are eligible for 50% federal matching funds.

This estimate assumes that MDH, in consultation with MIA, can develop recommendations for an appeals process for decisions made in accordance with contracts between a PBM and an MCO and report the recommendations to the General Assembly using existing budgeted resources. Further, MDH can apply for a federal waiver with existing budgeted resources. This estimate does not reflect any potential costs for Medicaid associated with the provision of any professional dispensing fees or other measures for pharmacies to ensure access to pharmacy services.

Small Business Effect: To the extent MDH provides professional dispensing fees or other measures for pharmacies as specified under the bill, small business pharmacies may benefit.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 6, 2019
mm/ljm Third Reader - March 26, 2019
Revised - Amendment(s) - March 26, 2019

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510